pharmacists planning service

NEWSLETTER

P. O. BOX 1336, SAUSALITO, CA 94966 JULY - SEPTEMBER SUMMER -THIRD QUARTER, 1995

Alioto and PDF Strike Again!

New Lawsuit Against Manufacturers For Exclusive Contracts And Kick-Backs

Joseph L. Alioto, Esq.

SAN FRANCISCO — Pharmacy Defense Fund of Sausalito, through Fred Mayer, its director, and Lynn Carman, its lawyer, continued its assault on monopoly practices in the prescription drug industry by filing suit in San Francisco Federal Court June 8. The suit charges Merck-Medco with antitrust violations for making exclusive-dealing contracts covering prescription pharmaceuticals with the nation's largest health plans, HMOs and employers, including the California Retirement System's 1,000,000 members.

Medco Containment Co., recently acquired by Merck & Co., the world's largest drug company, for $6.7 billion, was charged with procuring a 10-year exclusive contract by paying a kick-back of approximately $4,000,000 annually to the state agency, which bills itself as the largest pension fund in America and the third largest in the world.

Medco is accused of excluding all 60,000 pharmacies in the country from filling prescriptions of more than 30-day supplies for Medco's insurance, HMO and employer health plans (third-party plans), which cover 45 million Americans, and that Medco arbitrarily permits only chains, primarily, to fill prescriptions for its largest nationwide third-party plans, such as those of General Motors, General Electric, Blue Cross of California, and the Blue Cross and Blue Shield Association. Thus most pharmacies are excluded by Medco from participating in most of the prescription business involving 17% of their customer base.

Pharmacy Defense Fund in 1993 sponsored the first suits in the country on behalf of neighborhood pharmacies against the major drug companies for granting massive discriminatory discounts to Medco's mailorder prescription drug warehouses in Las Vegas and 10 other locations throughout the country.

"These no-bid exclusive contracts for prescription drugs divert millions of dollars from the nation's pharmacies to Medco's Las Vegas mailorder warehouse," said Fred Mayer. "Community pharmacists have sought, but were denied, the right to participate in these Medco exclusive contracts.

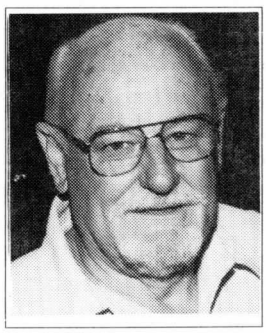
The suit's plaintiff is Harbor Drug Company, dba Stevens Pharmacy of Costa Mesa, California. Its president, Chuck Bonner, said it was a representative suit for California's 5,100 and America's 59,000 community pharmacies.

The suit was filed by attorney and former San Francisco Mayor Joseph L. Alioto and Lynn Carman. Alioto said, "These massive

See **NEW SUIT**, *Page 12*

Commentary

PBMs, Managed Care and Managed Costs



Marcel Laventurier, R.Ph.
Guinda, California

From a seminar given March 30 at Hyatt Sacramento

PBMs or pharmacy benefit management corporations were once called third-party drug plans. These plans were organized in the '70s to expedite payment of prescription drug claims, to act as clearing houses for invoices for drug insurance plans and to issue checks to the providers of pharmaceutical care. By using computers to pay claims, we were able to develop the first drug, patient, physician and pharmacy profiles to assist in preventing fraud, drug abuse and drug-drug interactions. Originally, drug utilization review (DUR) was designed to protect the patient and to provide a measure of accountability to the insurers. It is ironic that DUR was violently opposed by the pharmaceutical manufacturers in the '70s.

With the advent of managed care, PBM functions have changed dramatically and expanded geometrically. PBMs now cover over 200 million Americans. Besides Medicaid, PBMs were the first to fix the price they would pay for prescription services. Next, they fixed the cost of the ingredients they would pay pharmacies for and devised restrictive formulary lists of products they would pay for. Soon, like grocers who demand payment from manufacturers for shelf space, they demanded and got larger and larger kick-backs from the pharmaceutical manufacturers for inclusion of their products in the PBM formularies. PBMs became cash cows. The state of California's

See **PBMs**, *Page 15*

In This Issue

Marcel Laventurier - PBMs, Managed Care and Costs 1
Morris Boynoff - What Do the Big Guys Want? 2
Fred Mayer - Who Will Control Drug Distribution? 3
Stan Hartman - View North - Who's Getting Rebates? 4
Phillip Grauss - Tech Check Tech 5
Steve Rosati - Notice to Employee Pharmacists 6
J.W. Lewis - Alcoholism: The $$$ Facts 6
Donald Vaught - Musings on APhA Convention 7
Lowell McNicol - The 6253d U.S. Army Hospital 8
Jack Light - The Brave New World of PBMs 9
Joseph Rotenberg - FDA Under Attack 13
Cholesterol and Heart Health ..... centerfold poster
Legal News - In The Courts, etc. 11-14
Letters - 16-17 Announcements - 9, 18 Travel - 19

P.P.S.I. Travel News

JULY 13

Pharmacy Council on Alcohol Abuse two-hour CE Program, with Darryl Inaba, Pharm.D., for Santa Clara Pharmacists Association, Mariani Restaurant, Santa Clara, contact: Donald Renelli (408) 268-2519

JULY 17

PPSI Membership/Board/Manufacturer Meeting, Alta Mira Hotel, Sausalito (for overnight reservations at the Alta Mira Hotel please call (415) 332-1350 and also RSVP to PPSI (415) 332-4066

JULY 29-AUGUST 1

National Pharmaceutical Association (NPhA), representing African American pharmacists, Annual Meeting, Holiday Inn Crowne Plaza, Redondo Beach, California; Contact: Johnnie Early, II, R.Ph., Ph.D. (803) 792-8450

AUGUST 5-13

Pharmacy From the Rainforest Workshop, Costa Rica, Texas Pharmacy Foundation with American Botanical Council, contact: Charlotte deFrances (800) 633-4724 or Wayne Ewen (TX Pharm. Assoc.) (800) 505-5463

AUGUST 26-27

PPSI Public Health Pharmacy Issues Conference, Sheraton Stockholm Hotels Stockholm, Sweden; Contact: PPSI

AUGUST 28-SEPTEMBER 3

55th World Congress of Pharmacy/FIP, Stockholm, Sweden

AUGUST 28-SEPTEMBER 4

"CE at Sea" cruise to Alaska, co-sponsored by CPhA Educational Foundation and the Iowa Pharmacy Foundation, Contact: CPhA (916) 444-7811, Ext. 332

SEPTEMBER 3-8

Second International Conference on Affective Disorders, Jerusalem, Israel

SEPTEMBER 10-15

13th World Congress of Psychosomatic Medicine, Jerusalem, Israel

SEPTEMBER 15-18

British Pharmaceutical Conference, University of Warwick, Coventry, Contact: Lorraine Johnson, RPSGB, (Telephone 0171 735 9141 Ext. 275 - Fax 0171 735 7629)

SEPTEMBER 29-OCTOBER 1

1995 Western Pharmacy Education Faire (12 hour CE program), San Francisco Marriott; Contact: Conference Planning (916) 444-7811, Ext. 316

OCTOBER 7-11

National Association of Retail Druggists Annual Meeting
Hilton Hotel, Las Vegas

OCTOBER 9

1-3 pm, PPSI Annual Meeting
4:30-6:30, New Treatment in Alcohol and Substance Abuse; Marcus Cook, Pharm.D.; Barry Bleidt, Ph.D.
Hilton Hotel, Las Vegas

OCTOBER 10

7-9 am, PPSI George S. Maggio Memorial Breakfast
Hilton Hotel, Las Vegas

OCTOBER 28-NOVEMBER 1

National Wholesale Druggists' Association Annual Meeting, Marriott Desert Springs Resort, Palm Desert, California

OCTOBER 29-NOVEMBER 2

American Public Health Association Annual Meeting, San Diego

ROSS TRAVEL
1-800-634-4445

Membership Application – Annual Membership January 1 - December 31

Pharmacists Planning Service Inc., P. O. Box 1336, Sausalito, California 94966

Annual Dues $150 • (retired/senior $75)

❑ My check for annual dues is enclosed

❑ New Member ❑Renewal ❑Retired/Senior

Name _____

Business _____

Address _____

_____

City _____ **State**_____ **Zip** _____

Telephone ( ) _____

If you are already a member, please pass this on to another pharmacist.

PPSI Membership Benefits

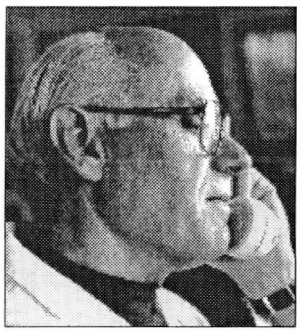
Please send information on the following:

- **CONTINUING EDUCATION/TRAVEL PROGRAMS**
- **LOW-COST GROUP INSURANCE**
  - ❑ Malpractice ❑ Medical ❑ Property
  - ❑ Disability ❑ Live ❑ General Liability
  - ❑ Business Auto ❑ Worker's Compensation
- **BUSINESS PLANNING**
  - ❑ Pharmacy For Sale ❑ Pharmacy Wanted
  - ❑ Legal Services (CA only) ❑ Group Rate Photo Finishing
  - ❑ Bad Debt Collection Help ❑ Paper Bags
  - ❑ Coin-oprated Copy Machine ❑ Investment Counseling
  - ❑ Low Cost Medicaid Billing Service
- **EMPLOYMENT SERVICES**
  - ❑ Pharmacist Needed ❑ Pharmacist Available
  - ❑ Vacation Relief Needed (Month) _____
- **NATIONAL GROUP BUYING COOPERATIVE**

Editorial

What Do The Big Guys Want?

Morris Boynoff, B.S. Pharm, R.Ph.
Editor, PPSI Newsletter



Part I. As has been reported in several sources, Wyeth-Ayerst is currently arguing that the application pending for license to market a generic equivalent to "Premarin" be refused. The challenge is based on the allegation that the competing molecule is not bioequivalent because it lacks a molecule that is present in the brand-name product. That the missing molecule is regarded by some prominent chemists and pharmacologists as inactive has little impact on those fighting to remain sole providers of equine-generated mixtures is not surprising. A piece in one of the drug magazines asserted that "Premarin" sales amount to several millions per day.

One surprising aspect (at least to this writer) was to become aware of the fact that the executive vice-president of the APhA wrote a letter to Dr. Kessler asserting that the generic and the brand products were not bioequivalent, even after the word from other sources (including FDA personnel) indicated that the products were bioequivalent and that the new kid on the block would be given marketing approval.

The PPSI Newsletter

Morris Boynoff, B.S. Pharm., R.Ph., Editor
Nicholas Wilson, Production

Published quarterly on the first of January (Winter), April (Spring), July (Summer), and October (Fall), by

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FAX 707-937-1846

Meanwhile, Wyeth personnel, including an APhA past-president, are reported as filing a suit, asking the court to deny approval.

Stay tuned!

Part II. Eli Lilly & Co. were delighted by a jury verdict last December in a lawsuit that challenged the safety of Prozac, calling the victory "a complete vindication of the medicine." Not included was the information that a secret deal had been made with the plaintiffs before the case went to the jury (even the judge wasn't told). The deal came to light when the judge filed an unusual order to change the verdict "dismissed with prejudice" to "dismissed as settled." He suggested that the damaging evidence about Lilly's prior dealings with FDA were never presented to the jury. The evidence would have shown that Lilly faced criminal charges in 1985 when another of its drugs (Oraflex) was taken off the market after "dozens of patients died." The company then pleaded guilty to 25 counts of failing to report patients' adverse reactions to the anti-inflammatory. A Lilly executive who headed the company's research division also pleaded guilty to 15 criminal counts. If memory serves, the company wound up with a minuscule fine, amounting to about one or two thousand dollars per death, which is a small amount for fatalities caused by anxiety (greed?) to market the first non-steroidal anti-inflammatory in the U.S.

Answer to the headline question: MORE!

Best Offer of the Year

A Fort Lauderdale newspaper, the Sun-Sentinel, in April of this year ran a piece captioned "Profits From Pain." It was a journalistic exposé warranting close study by states contemplating quick-fix solutions to health care crises. Quote: "People contemplating government reform should be careful what they wish for; they might get it."

This paper published a cautionary tale entitled "Profits From Pain." Written by Fred Schulte and Jenni Bergal, it truly deserves a Pulitzer Prize. Copies of a special reprint of the series may be obtained without charge by writing to the Customer Service Department, Sun-Sentinel, 200 East Las Olas Boulevard, Fort Lauderdale, FL 33301.

The accounts of deceit, fraud and depriving enrolled persons of needed care should jar all legislators who might be considering the HMO approach as a quick fix solution to the health care crisis. The publishers of the Sun-Sentinel are to be lauded for their fortitude in bringing sleaze, deceit, fraud and plain old theft to the attention of the public.

At a cost of a postage stamp on the envelope, the series is available in newspaper format, allowing pharmacists to use the information whenever a state or municipal legislature starts debating on the merits of dumping public money into the pockets of entrepreneurs who take the money and run.

One has to read the documentation to learn, and believe, how much sleaze, theft and deceit has surfaced, explaining how the money spent to provide care to indigent patients has been diverted to big cars, big salaries and big dividends to stockholders.

Be a sport and buy the stamp!

Deadline for Fall issue is August 15
Contributors please send a portrait photo, color or black and white, any size up to 8 x 10.

Message from the President

Who Will Control Drug Distribution?

Frederick S. Mayer, R.Ph., M.P.H.
President, PPSI

Since time immemorial, the pharmacist has been charged by society to be the keeper and dispenser of the potent remedies, poisons, and other dangerous substances capable of injuring patients.

In fulfilling this function he has been honored with the public's trust. Pharmacy is the most respected profession in the nation, topping the Gallup polls six years in a row. But I believe that pharmacy will soon be the most despised. Scandals about dispensing errors are occurring with troubling frequency. When patients were given mislabeled, misdosed, wrong prescriptions, where were the pharmacists who bear the ultimate responsibility for protecting the patient against dispensing mistakes?

Who is to blame? We all are if we let it happen and hide our heads in the sand. Those most to blame are those who thumped for the use of technicians and loosening the regulations designed to protect the public in the dispensing of prescriptions. Today anyone, including convicted felons, can repack, relabel and distribute dangerous drugs to an unsuspecting public without regard for safety and accuracy. This is a prescription for disaster. You can be sure that a single registered pharmacist overseeing numerous technicians in a drug mill where 500 to 1,000 Rxs are sent out per day, will on the average allow 30 to 50 errors to slip through. Perhaps only three to five errors will be of sufficient magnitude to land the patient in the hospital. Nowadays, with hospitals short on registered nurses and registered pharmacists, but staffed by legions of "techs," LVNs, and orderlies, pills and injectables will be speeded to the patient's bedside under the "supervision" of a hospital pharmacist, a barely regulated activity where management demands speed over accuracy.

As more and more incidents of gross pharmaceutical errors are reported, the public will begin to revile pharmacists for failing in their duty to protect the patient. It doesn't take a rocket scientist or Ph.D. from Harvard to find evidence to show that more and more patients are going to the hospital due to lack of counseling. In fact, Inspector General Richard P. Kusserow focused a report specifically on the consequences for older adults, the largest users of pharmaceuticals. According to his report Americans aged 60 and over comprise only 17% of the population, but account for 39% of all hospitalizations and 51% of the deaths resulting from drug reactions. In one year, 1985, more than 240,000 older adults were hospitalized due to adverse drug reactions, interactions, allergies, etc., with 100,000 dying, at a cost of $10 billion. Has anybody not seen the Diane Sawyer "Primetime" TV program about 274,000 prescription drug errors a day made by pharmacists? If you extrapolate, California has 10% of the population, and in California alone this would amount to 27,000 prescription drug errors per day.

Soon, pharmacists will be redundant anyway. Under managed care and disease management protocols, once a diagnosis is established the big pharmaceutical firms who own the PBMs can ship their brand of remedies direct from the factory to the patient's mailbox, unsullied by the pharmacist's intervention, with the full blessing and tacit approval of the various boards of pharmacy. Allowing dangerous drugs to be distributed without professional supervision, without checks or thoughtful deliberation, and without consultation invites mischief on a grand scale. Those responsible for this outrage — the professors, the academics, the bean counters, the PBMs, the con men and women in the pharmaceutical industry who are buying up the PBMs, the hospitals and HMO directors, the pharmacy board members, the pharmacy association leaders — should be held liable for their actions not only in harming the public but also in endangering our professional reputation.

PPSI Board Policy Statement

Patient-Pharmacist Covenant

Pharmacy is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges pharmacists to be competent and to use their competence in the patient's best interests. Pharmacists, therefore, are both intellectually and morally obliged to act as advocates for the sick, blind, poor, elderly, retirees, halt and lame wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimization of the pharmacist's materialistic self-interest; from without, for-profit forces press the pharmacist into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the pharmacist's responsibility degrade the pharmacist-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the pharmacist's role as healer, caring helper and advocate for the sick and for the health of all.

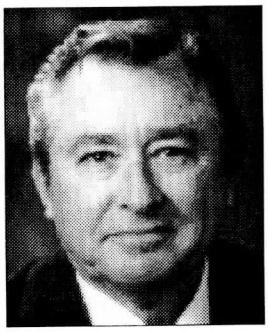
By its traditions and very nature, medicine is a special kind of human activity — one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark pharmacists as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Pharmacists, as pharmacists, are not, and must never be, commercial entrepreneurs, gate-closers, agents of drug companies, or agents of fiscal policies that run counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment that may compromise quality of or access to good pharmaceutical care.

We believe the pharmaceutical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research and pharmaceutical organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate pharmaceutical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

A View From The North

Who's Getting The Rebates?



Stan Hartman, R.Ph.
Portland Retail Druggists Assn.

A few of you may recall that in our last communication we attempted to present the research of Dr. Ernst R. Berndt of the Massachusetts Institute of Technology. Dr. Berndt furnished a philosophical viewpoint for the maintenance of price discrimination in the prescription drug industry through a publication of the American Enterprise Institute titled "Uniform Pharmaceutical Pricing — An Economic Analysis." Dr. Berndt was funded by Merck.

Dr. Berndt's philosophy is important because it is his philosophy that the drug companies are selling in the Oregon Legislature to kill House Bill 2763. I cannot predict what will happen to HB 2763 in Oregon but I can predict that the drug manufacturers will be working this state with a satchel full of chump change to sway opinion. The May 10th Oregonian editorial headline, "Druggists Want To Give You A (Price) Fix," is evidence of how serious the drug manufacturers are about this legislation.

I believe that if the Oregonian and Merck prevail, this price discrimination cat can be cornered by an up front change in public policy. I suggest that we take another look at the Oregon Medicaid program which now encompasses a huge new population with entitlements crafted by Dr. John Kitzhaber and granted by the Oregon Legislature. The Oregon Health Plan utilizes Title 19 and the appropriate Oregon Statutes augmented by waivers especially granted by the Clinton Administration under the leadership of Secretary of H.H.S., Donna Shalala.

Under Title 19 conditions and stipulations, fee for service prescription service is so crafted that reimbursement formulas are based upon known industry pricing structures that allow the state of Oregon to capture earned discounts from providers, fix a dispensing fee, and most importantly capture Wyden/Pryor rebates pursuant to the OBRA 90 statutes.

It is my understanding that an OBRA rebate is gained from the manufacturer for the benefit of the state of Oregon on bona fide purchases of a given drug company's prescription product. Lilly, for example, currently sells Humulin N to a Portland for-profit hospital at $8.04 per 10 cc vial. It is my guess that if this is Lilly's lowest price, then they must rebate to Oregon the difference between $8.04 and their wholesaler acquisition cost. Currently the State of Oregon is picking up about $5 million per fiscal quarter in rebates. Another $1 million is in dispute and subject to negotiation.

Strangely, the rebates are flowing in at about historic levels in the face of another condition that would seem to contradict this fact. The new population in the Oregon Health plan are cared for on a contract basis by so-called managed-care firms such as HMO Oregon, Kaiser, Qualmed, etc. These firms apparently escape traditional billing and their prescription dispensing seems to be outside the OBRA 90 rebate process. Well, where is the rebate going?

It is also of interest that the managed-care firms are not bound by the Oregon Legislature or the law when it comes to formularies. The fee for service system has a statutory provision that prohibits formularies. There is a nuisance program called "Prior Authorization" that attempts to limit dispensing for ulcer drugs and other high-end items. Physician's Association of Clackamas County (PACC) does not believe in brand or generic Ceclor. Could this have anything to do with the fact that Smith-Kline-Beecham's Pharmacy Benefit Manager, Diversified, has an allergy to Lilly labels?

I believe that the Oregon Health Plan should begin a program to immediately "access" the OBRA rebates from all contractors that provide prescription drugs to the Oregon Health Plan population.

California's Medi-Cal program could implement a similar program in its "Geographic Managed Care" (GMC) system. This would be a perfect time to consider this notion in implementing the OPTIMA program in Orange county.

Currently, the greasy street language in managed care is how efficient and cost effective and price sensitive pharmacy benefit managers and health maintenance organizations are in contrast with the greedy street providers who are working from bone marrow. A corrupt system of secret contracts and "highly confidential" contracts needs to be broken. Salem, Sacramento, and Chicago would be a good place to start the process.

A DISEASE YOU DON'T WANT TO THINK ABOUT IN A PLACE YOU DON'T WANT TO TALK ABOUT™

COLORECTAL CANCER
(PUBLIC CANCER ENEMY #2)

September is National Colorectal Cancer Awareness Month, sponsored by PPSI and the National Cancer Institute. For brochures, literature, and posters call NCI Cancer Hotline at 1-800-422-6237

NDMA Challenges OTC Labeling Proposal

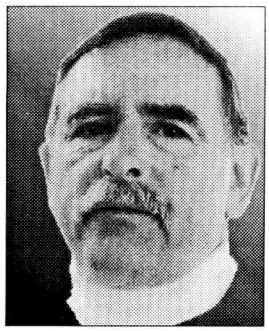
Am I Missing Something?

The Nonprescription Drug Manufacturers Association (NDMA) is opposing an FDA proposal that would require the list of OTC active ingredients on the front panel of the package in a type size not less than half that of the brand name. "Forcing too much information on the principal display, information that is now on the side or back panels, would reduce the consumer's ability to identify brands of choice from among the product options on retail shelves," said Bob Donovan, a senior vice president at Sandoz and NDMA chairman, at the NDMA's annual marketing conference.

PPSI filed a Citizen Petition with FDA in 1991 to make print size on OTCs larger. What's going on?

Guest Editorial

Tech Check Tech Proposal



Phillip Grauss, Pharm.D.
Pres., Marin County Pharmacists Assn.
Novato, California

Dear Colleague,

The May 24, 1995, California Board of Pharmacy "Informational Hearing" regarding the use of technicians in pharmacy and technicians checking technicians (Tech Check Tech, or T-C-T) in the hospital setting brought forth some controversial and emotional viewpoints.

The opposition to Tech Check Tech stated succinctly that the it was an unwieldy, dangerous, and illogical proposal, based on the argument that patient safety is jeopardized. That, of course, is something the Board of Pharmacy is mandated to protect.

After all, when 19 California local associations, the California Pharmacists Association, California Employee Pharmacists Association, United Pharmacists Local 24, the Guild, Pharmacists Planning Services, Inc., the American College of Apothecaries, and *all* locals of the United Food & Commercial Workers union (UFCW, with over 100,000 members) all stand *united* and *opposed* to Tech Check Tech, you might think someone would listen. The message delivered was loud and clear. T-C-T is an ill-advised idea that potentially can cause great patient harm.

Consider this:

- Inpatient technicians need not be registered with the State Board of Pharmacy at present. Most were "grandfathered" into their current jobs.
- No criminal background check for inpatient technicians is required.
- There is no minimum education requirement for inpatient technicians.
- There is no liability burden on technicians.

Thus, there exists the possibility of the following worst-case scenario. Imagine a high school dropout with a criminal background checking the work of another high school dropout with a criminal background. In outpatient pharmacy, these technicians would have to be registered, but not in inpatient pharmacy. Theoretically, this work would then be checked by a registered nurse, except that there are no RNs on the floors doing this task. The administration of the drug to the patient is mostly performed by LVNs or other ancillary help. In fact, many LVNs have never even heard of the drug being sent them to administer.

The fact emerged at this hearing that over 50% of HMO/Hospitals (a low figure) are in fact practicing T-C-T, even though the Attorney General of California admitted that the practice is totally illegal in California. He stated that "the hospitals and HMOs currently practicing it should be cited."

Regarding liability for T-C-T, the pharmacist-in-charge will be held accountable for any mistakes or liability, even if the pharmacist was not physically present in the room or involved in the process.

Further, the deterioration of pharmacy service and quality control was discussed. Reality today demonstrates that since technicians have replaced pharmacists in the work place (there are now approximately 13,000 technicians in California, not including the unregistered inpatient techs) pharmacists find that:

- stress levels have increased
- error rates are increasing
- patient consultation times are decreasing
- burn out or emotional stress disability leaves are increasing.

Why? Because the replacement of a pharmacist by a technician dictates *more* work for the available pharmacist.

Tech Check Tech is an unwise, dangerous and illogical idea. The Marin County Pharmaceutical Association calls it "incomprehensible." It represents the epitome of avarice. The use of uneducated, unregistered ancillary help, filling prescriptions unchecked by a licensed pharmacist, with no technician responsibility or liability, does not make sense. If cheap labor is the *raison d'être* why pick on pharmacy, when it only accounts for about six, maybe seven percent of the entire health dollar? Why would any responsible patient facility want to exclude or deny professionals that have spent a lifetime learning their profession — and earning a "number one in professional ethics rating" — the privilege of practicing their profession?

Pharmacists need to *protect* their jobs, and until someone else changes the law that gives pharmacists the right to dispense prescriptions (like Tech Check Tech would do) pharmacists need to become vocal and tenacious in their desire to maintain their right to practice pharmacy. When the concept of "pharmaceutical care" becomes reality and the method of reimbursement for it becomes fact, then, and only then, should pharmacists consider surrendering their dispensing function, and only to qualified individuals!

By *opposing* T-C-T, you are protecting public safety, you are protecting your investment in your education, and you are protecting pharmacy.

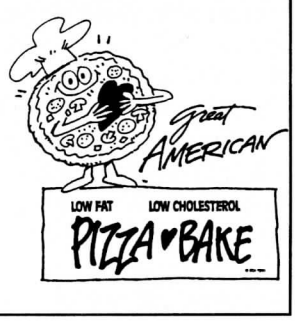
The "pharmaceutical-care era" is coming, no doubt. Also, no doubt we need technicians. But the pharmacists of California will not hand over their dispensing function until *they* say it is a good idea. When pharmacists finally acknowledge that the next plateau in pharmacy's future is in place, we will let you know. Until then, *protect your privilege.* Protect your right to dispense medications.

Editor's Note: Please send your comments on this matter to PPSI President Fred Mayer at P. O. Box 1336, Sausalito, CA 94966, or fax to 415-332-1832.

Take Note!

Sixth Annual Great American Pizza Bake (Low Cholesterol, Low Fat) will be held during the American Public Health Annual Convention, San Diego, Monday, Oct. 30, 1995, 9-11 am.

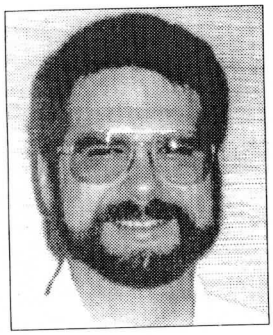
Location: Karl Strauss' Old Columbia Brewery, 1167 Columbia St., San Diego, CA 92101, phone (619) 234-BREW (2739).



Commentary

NOTICE TO EMPLOYEE PHARMACISTS

Stephen J. Rosati, R.Ph.
Hollister, CA 95023



I attended the May 24 California Board of Pharmacy hearing regarding the use of technicians, and technicians checking technicians in the hospital setting. In many cases, the working environment has improved with the use of technicians. However, in other cases, their use and ratios have led to less pharmacists per shift, increased stress and pressure, and sometimes chaos when the workload peaks and questions/problems with third-party administrative needs occur. Sometimes there is not enough ancillary staff per shift, allowing the pharmacist little, if any, time to provide consultation to the patient, and work in a safe and efficient manner.

Those providing testimony to the Board at this hearing presented many of these employee-related problems based on behind the scenes complaints from employee pharmacists. However, the Board looks at this type of testimony and complaints as simply hearsay. The Board cannot act to help resolve the problems unless they hear it from you directly, because they have no concrete evidence that problems are occurring in the workplace. You need to put these problems down in writing, while being very specific about the causes and effects, the location of the business, and send them (anonymously if you wish) to both:

Patricia F. Harris, Executive Officer
California State Board of Pharmacy
400 R Street, Suite 4070
Sacramento, CA 95814

Robert P. Marshall. Executive Officer
California Pharmacists Association
1112 I Street, Suite 300
Sacramento, CA 95814

I realize it is a difficult position that you are put in because of the fear of reprisals, or losing your job. However, if you are not willing to put it in writing and send it anonymously, then you will have to continue putting up with the problems. Your work environment will not improve unless you provide input in writing to those who can legally help you.

P.S. An interesting note: It appears that if a technician checks another technician's work (*currently* proposed just for hospital setting, but no doubt something community pharmacy will be facing in the future), then the pharmacist-in-charge will be held accountable for any mistakes or liability, even if the pharmacist was not physically present in the room or involved in the process! Employee pharmacists who currently are involved in this "practice" of technicians checking technicians (that the Board of Pharmacy currently says is not in compliance with existing law), or plan to become involved in such a program in the future, may wish to seek a legal opinion, or call the Board of Pharmacy (916-445-5014) if you have any questions or concerns, before you offer your services and license for such a program.

Commentary

Alcoholism: The $$$ Facts

J. W. Lewis, Pharm.D., M.P.H
Advisory Board Member, Pharmacy Council on Alcohol Abuse
Wilmington, Delaware

What is the most expensive disease in the US? A major runner-up in this category is alcoholism. Annual cost estimates for this disease range from $96.9 billion to $116 billion per year. Why is alcoholism so expensive? In 1988, 15.3 million people over age 18 were alcohol abusers or dependent on alcohol. Alcoholism is associated with a wide range of costs including treatment costs, medical costs for the treatment of alcohol-related complications (e.g. cirrhoses of the liver), treatment and care of children with fetal alcohol syndrome, premature death, unemployment, decreased employment, and crime. Alcohol-related injuries alone account for about $47 billion each year; this represents a cost of $5 million every single hour!

Alcoholism and abuse of other drugs is estimated to consume as much as 15 cents of every health care dollar. In 1994, one out of five Medicaid dollars for hospital care and one out of four Medicare dollars for hospital care was due to alcohol and other drugs. In 1993, federal, state and local governments spent about $3.5 billion for state-supported alcohol and other drug services.

Health care costs account for only about 10% of the total costs of alcoholism. However, individuals with alcoholism are high users of health care. In the US, 20-40% of hospital admissions are caused by complications of alcoholism. Use of medical services is 100% higher for alcoholics than for non-alcoholics, and costs may rise to 300% higher prior to a medical crisis. Sadly, even the health of families can be affected by an alcoholic member. Children of alcoholics have a 62% greater hospital use rate than children of non-alcoholics and, on average, have hospital costs that are 36% higher. Fetal alcohol syndrome is estimated to cost as much as $3.2 billion per year.

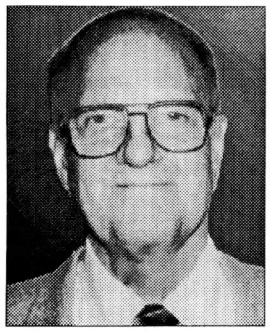
Treatment for alcoholism is cost-beneficial with a return of between $2-$10 for every $1 spent. This cost saving effect has been demonstrated with programs that include counseling, group therapy and/or medical therapy. After recovery, health care costs decrease an average of 40%. Recovery can decrease sick days, injury days, and days absent from work by 30-60%. Data from the California Drug and Alcohol Treatment Assessment (CALDATA) study found that recovery decreased involvement in criminal activities by nearly 80%.

What can pharmacists do to decrease the costs of alcoholism? First, be conscious of the potential for alcoholism and don't assume that the patient's doctor has addressed the issue with them. Providing information about alcoholism, the benefits of treatment, and sources of care can be a valuable service to patients and their families. For those patients receiving drug therapy for their addiction (e.g., Antabuse or Revia) encourage them to remain in treatment. Long-term monitoring of their adherence to therapy and abstinence is key in preventing relapses. Remember, the pharmacist is the health professional they are likely to see most often! Finally, realize the impact of alcoholism on the family by providing information and support to family members and encouraging them to seek professional care when needed.

Vibrations from the Heartland

Musings on APhA Convention 1995

Donald V. Vaught, R.Ph.
Past Pres., Illinois Pharmacists Assn.
Riverdale, Illinois



Not having ventured into a Disney domain since 1978 when I took the three-year cure and became an APhA Trustee, it was with trepidation that I heeded my girlfriend of 45 years and wife of 40 years and visited EPCOT one day before the start of the APhA convention. You see Alice had a three-day freebie there about three years ago as one of George Bush's thousand points of light. Which point she was remains obscure, but she was suitably impressed, as I was, how tourists can be mercilessly exploited while enjoying every minute of it.

I can report that the APhA convention was enjoyable, the programming good, the exhibits superlative. APhA is in many ways still a splendid pharmacy organization, although among the 5000 attendees or so there might have been only 500 community pharmacists, counting both independent and chain.

So, what are the problems?

1. Malaise — The APhA-Merck-Medco endorsement would have been the proper decision if you were dealing with honorable people. Unfortunately, they were dealing with bottom-line folks who did not share the tender dreams of APhA. They lost membership and paid the price. When I called several non-returning members in mid-summer, 80% mentioned the Merck-Medco endorsement. APhA has recanted, but I hope next time there are more folks among the trustees to throw up warning flags, and they check it out with the old farts brigade, who must be good for something.

2. Membership — Of 46,000 members, 12,000 are students. The real problem is that more than half the remainder are not full dues paying members, being less than five years out of school. When the dues are doubled that last year to 60 bucks, a lot of these 50-to-80-grand-a-year pharmacists head south.

3. Drug Companies — They pay for everything: CE, functions, exhibits, even the damn pins for the one symbol of pharmacy that President Bob Davis was pitching during his inauguration. It said Ciba-Geneva, which leads me to believe they have liquidated Mr. Geigy, and I want an investigation. Local, state, and national pharmacy associations spend so much time worrying about their revenue streams that they don't want to offend the drug companies too much.

I threw into New Business in the APhA House of Delegates the pronouncements of a drug company yutz that they really haven't raised prices so much, and the price of a prescription is like the list price of a car, with savings of 300% available by shopping around. All I said was they should be rebuked for their non-truthful presentation of the facts. There was sympathy, but most delegates didn't want to stir up the waters. Now, I can understand that if I had advocated they should be drawn and quartered or shot....

The court suits are truthfully looked on with disfavor by many pharmacy associations, including APhA. The funny part was that Fred Mayer asked me to be moderator of the session on the Pharmacy Defense Fund and the Texas Freedom Fund efforts on the giant suit in Chicago, and the California actions, which made three talented lawyers. APhA realized it was their convention and room, so Bill Hermelin, the legislative liaison of APhA, became the moderator, and brought in two more lawyers, again talented in the state association suits against price discrimination to keep the associations happy. Fine by me, I got to watch five fine lawyers, with an occasional scrap; a fascinating two hours. Associations by nature shun the open conflict (with the exception of PPSI) and mouth those unforgettable words, "let's work with them." After what the drug companies have done to the community pharmacist, I now understand the mindset of Neville Chamberlain wanting to appease Hitler. If that had worked the last 40 years, we should try it. The bottom line for all associations is that they have the hard choice of being the manufacturers' lapdog or raising dues a bunch, which will lose them membership.

4. New Directions — All this Pharmacare movement is great, but that is for a minority of pharmacists, plus they gotta get paid for it. It is exciting and the future for many. Let us also remember that Pres. Bob Davis' company just bought Pharmacare over a rival bidder, APhA. That is a problem. *

5. Conflict of Interest — During the 25-year reign of Bill Apple, there was hardly a conflict of interest, because he would burn you. Now, with all the changing conditions, APhA hopefully will bend over backwards to avoid conflicts of interest. The mutterings are out there. How true they are, I don't know.

My conclusions about the court suits, from a close, yet faraway view.

1. The state association suits are an add on, and are unnecessary, but the state associations felt they had to do something, but giving to the PDF and Freedom Fund obviously was not it.

2. The kind of court suits filed in California and the action in Chicago should have been done with national association leadership, be it NARD or APhA, not funded leadership. This to me is proof that we have lost our way.

3. They have the drug companies cold turkey, so the possibility of an out of court settlement exists. They sure as hell have attempted it in the state of California.

4. Even if pharmacy wins overwhelmingly, the drug companies will eventually figure out another scheme to profit. If it gives us a new shake of the dice, it is worth it.

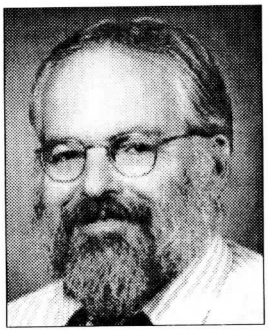
5. There may be a lot of money, but lessening discrimination of price is what will help the community pharmacist.

Merck at APhA — Merck was there, of course, but I noticed mostly their subsidiaries like Endo, Astra, DuPont, etc., carrying the heavy water. For some reason the name Merck doesn't have the same cachet it once had. Remember when Percodan was made by Endo? Seems a tad strange for them now to market the generic version of Percodan. Perhaps it is no stranger than buying Duramed acetaminophen No. 3 made by McNeil, or Myland Cefaclor made by Lilly, etc. I loved it when one of our suppliers stopped carrying Mova's (Schering) Albuterol liquid on the grounds that it was not approved in the Illinois Formulary.

** Editor's Note: APhA President Robert Davis has resigned over the possible conflict of interest mentioned above.*

Commentary

The 6253d U.S. Army Hospital



Lowell McNicol, Pharm.D.
Petaluma, California

During the years 1966 thru 1972, I was attached to the 6253d U.S. Army Hospital. It was an Army Reserve unit based at the Presidio of San Francisco, and was a 1000-bed paper-hospital, the largest of its kind in the United States. Its ranks were filled with hundreds of young professionals who were eager to avoid service in Vietnam, myself included.

A remarkable thing occurred there 25 years ago, which is worth retelling. One of my friends in the unit at the time was a young CPA (certified public accountant) who was assigned to the Personnel Section. He told me that the top brass of the unit had ordered the Personnel Section to perform a study of the IQ's of the professionals assigned to the unit, ranked by profession. The top brass of the unit were all physicians, and as with many ill-conceived and poorly planned studies, the result was preordained. Physicians, of course, would be found to have the highest average IQ. The study was to be a simple exercise in self-gratification for the high ranking physician officers of the unit.

The actual result was a disaster. The Personnel Section had not performed any IQ tests. They simply tallied the results of IQ tests which were in the Personnel files of the various professionals. These had been administered as part of a battery of tests completed by each soldier prior to admission to the Army. The professionals tallied were physicians, dentists, nurses, pharmacists, lawyers, optometrists, podiatrists, physical therapists, and CPAs. To the extreme distaste of the top brass, pharmacists came out with the highest average IQ.

Reaction was swift and severe. The study was destroyed. So, all we have is my anecdotal account of it. The study may be criticized as being unscientific, but its simplicity and honesty are remarkable. Somebody did the testing, and somebody else averaged the results according to category. It could be argued that the result with pharmacists was not significant because there were too few of us. I think there were about eight pharmacists in the unit at the time. But I like to think differently. We had come from various pharmacy schools in different parts of the country and contrasting ethnic backgrounds. In any case, the result was desperately discomfiting to the "leaders of the health-care team."

I recount this story because there are some lessons to be learned here. The first is that a high IQ does not guarantee success in one's professional life. There are other things equally important, not the least of which are drive, stamina, aggressiveness and insight. I think that if pharmacists had exhibited more of these qualities over the last 25 years, our profession would not be in the sad situation it now finds itself.

The second lesson, and probably more important, is about self-esteem. Pharmacists historically have had a bad self-image. They have doubted their ability to contribute significantly to good health care. They have doubted their level of practical knowledge, compared with that of other health professionals, notably physicians. Some of that doubt may be well founded. There is a gulf between intelligence and knowledge. That gulf is ignorance. If a pharmacist can use his native intelligence to gain the right knowledge (the right stuff), he can shrink the gulf of ignorance to the vanishing point, and he can apply that knowledge combined with drive and aggressiveness and insight, to secure a very valuable position in human society.

It must be recognized that a valuable position is not given free of charge; it must be earned; it must be fought for. The father of modern economics, Adam Smith said it best in his book *The Wealth of Nations* in 1776. He said that the first rule of economics was "the dominant role of self interest." We must apply our knowledge combined with forceful drive, aggressiveness and insight to achieve what is in our own self-interest. Otherwise, we will perish. We can't allow large corporations and HMOs and managed care and boards of pharmacy to make our decisions for us, because they make decisions which are in their own self-interest. We can't allow ourselves to luxuriate in the thought that we are the "most trusted" profession, because if we do, we will surely become the "most extinct" profession.

We have allowed those who govern us, lead us, educate us, and regulate us, to view us with a paternalistic attitude. Apparently, pharmacists' abilities are viewed with such contempt, that the deans of at least two of the schools of pharmacy in California are not even pharmacists. The third, the dean at U.S.C., is new, and I don't have any information about him. The executive officer of the California State Board of Pharmacy is not a pharmacist, and neither are three members of that board. Our professional destiny is controlled in large part by a combination of arrogance and contempt, executed by intimidation.

This state of affairs is deplorable and intolerable, but it need not be permanent. The 6253d U.S. Army Hospital, with its long-buried, misguided IQ study, has given us the solution that we desperately need. It gives us the self assurance that we are smarter than the "rest-of-em'" and that therefore, we can wrest control of our profession from the grip of others, and can pursue our own self-interest. My friends, we have the tools for change; we need only use them.

Save The Dates

October 7-11
National Association of Retail Druggists Annual Meeting
Hilton Hotel, Las Vegas, Nevada

October 9, 1-3 p.m.
PPSI Annual Meeting
Updates on:
Pharmacy Defense Fund Litigation
Managed Care
Pharmacy Benefit Management (PBM) Issues
National Alcoholism Education and Awareness Campaign
Women's Health Campaign
Great American SmokeOut

October 10, 7- 9 a.m.
PPSI George S. Maggio Memorial Breakfast
honoring Arthur Perlin, P.D.
President, Long Island Pharmaceutical Society (LIPS)

Commentary

The Brave New World of PBMs

Jack Light
Vice President, PPSI
Former V.P. of California Medical Assn.

Toward the end of last year, a loosely knit group of about twelve individuals involved in health care got to talking about medical matters they knew to be important but difficult to assess. PBMs topped the list. Everyone had ideas about what PBMs do but there were diverse views on what they mean to the medical marketplace. On March 30, 1995, with considerable trepidation, this group, now calling itself the PBM Study Group, presented the first major conference on the mysterious phenomena of Pharmacy Benefit Management organizations. PPSI managed the conference. It was enlightening.

The makeup of the PBM Study Group includes the California Pharmacists Association, the California Medical Association, consumer advocacy organizations, the California Retail Association, a number of pharmaceutical manufacturers and Pharmacists Planning Service Inc. Members of the group act as individuals and not necessarily as emissaries of the organizations with which they are associated.

The purpose of the conference was to take an honest look at PBMs from a variety of viewpoints. The audience was a select group of health care decision makers, legislators and regulators who attended by invitation only. From the enthusiastic comments following the all day non-stop session, the conference was a success, and may spawn similar conferences later this year.

There were nineteen presenters including the Commissioner of Corporations, physician and pharmacist leaders, renowned experts on outcome analysis, corporate officers, practicing pharmacists, consumer advocates, economists and more. Here are some of the strongest themes that emerged:

- Confidentiality of personal information is a concern. Patient information belongs to the patient — and no one else. We must use the vast amount of data generated intelligently and for the benefit of the public, not commercial interests.
- Third party computerized review or processing systems can assist but cannot be permitted to override the judgment of the treating physician and pharmacist.
- Physicians and pharmacists must develop satisfactory working relationships with PBMs. PBMs are not going to disappear in the foreseeable future. Pharmacists and physicians can work together to assure that PBMs do not usurp the professional obligations of the health care providers. Independent physicians and pharmacists must participate in formulary selection. Patient needs and quality of care, not PBM profit motivation, must prevail.
- We can, in fact, have *better health care at lower cost* through intelligent treatment planning based upon the rational use of outcome studies.
- Medi-Cal and other governmental programs will gravitate toward managed care, including PBMs, because administrators are convinced that there are potential savings. Over the short run, however, the Department of Health Services will reduce Medi-Cal drug benefit expense by cutting wholesale prices, reducing professional fees to pharmacists and limiting the number of unauthorized prescriptions.
- Providers and beneficiaries alike must be vigilant against fraudulent enrollment and other possibly exploitative practices by managed care organizations.
- PBMs should be subject to Knox Keene style requirements that protect both providers and the public without stifling competition through excessive regulation. Patients and providers must have workable grievance procedures; disenrollment and enrollment practices must be regulated and appropriate; PBMs and managed care organizations must be financially viable before being permitted to operate in the marketplace.
- Health insurers are under tremendous competitive pressures and cannot offer price-competitive plans that feature fee-for-service and non-restricted access to providers of care.
- Retail pharmacies are being pushed to the brink by low PBM reimbursement rates and selective contracting. PBMs now control 80% of prepaid drug plans. Three PBMs control 80% of the PBM business. These days pharmacies must do business with multiple PBMs and third-party payers on a take it or leave it basis.
- To preserve their professional status at the retail dispensing level, pharmacists must re-define their role in the health care system.
- Poor quality health care is no bargain and drives the overall cost of care up, not down. A wide choice of medications is essential to quality care. The prescribing physician's judgment must prevail.
- We are gaining the ability to truly measure outcome. This assures that an enlightened public will opt for quality and good results over short-sighted cost/profit considerations.

Conclusion

There is little doubt that managed care and PBMs will continue to put pressure on retail pharmacy. However, there are countervailing forces at work that will tend to level the playing field. Mergers and re-alignments are likely to continue. Practicing physicians and pharmacists are coming to together. They are responding to perceived PBM challenges to their professional status and can work together to seek similar and mutually supportive solutions.

At some point physicians and pharmacists will draw the line and achieve more balanced relationships with PBMs — relationships that will allow the PBM to perform its tasks without undermining or complicating the professional and administrative roles of those who are providing direct patient care.

An informed public, the increasing availability of outcome data, and well-tested disease management systems can assure that quality is not sacrificed to short-term cost objectives. The healing arts must challenge managed care entities every time cost considerations interfere with patient care. Properly configured, "managed care" can mean better care and better value.

New Pharmacy Fellowship in Alcoholism and Addiction Treatment

The Pharmacy Council on Alcohol Abuse (PCAA) is proud to announce the funding of a new pharmacy fellowship in alcoholism treatment. DuPont Pharma is sponsoring the position at Idaho State University College of Pharmacy under the direction of Dr. Marcus Cook. The position will be based at the Veterans Administration Medical Center in Boise, Idaho.

"This fellowship provides a great opportunity to be on the forefront in disease and patient management of alcoholism and addiction", says Dr. Barry Bleidt, Co-Chairman, PCAA. "With new VA guidelines in place giving a larger role for pharmacists, this position, under Dr. Marcus Cook's leadership, will be the first of its kind."

"We are very thankful to DuPont Pharma, makers of ReVia (Naltrexone), for having the insight to fund such a progressive position for pharmacists," says Frederick S. Mayer, R.Ph., M.P.H., founder of PCAA. More information about the fellowship will be available in early June on the specifics of the program. It is anticipated that the position will have a September 1 starting date.

The Pharmacy Council on Alcohol Abuse is a non-profit organization dedicated to erasing the stigma associated with alcoholism by encouraging pharmacists and other health care professionals nationwide to educate and to counsel the public about this illness. PCAA brings together a unique group of prominent pharmacists, physicians, social welfare experts and consumer advocates to help the 17 million Americans each year who fall prey to this insidious disease.

Contact: Marcus Cook, Pharm.D., M.B.A., C.A.C., Co-Chairman, Pharmacy Council on Alcohol Abuse, phone (208) 389-0989, or fax (208) 389-7947

Alcohol-Medication Interactions Brochure

Many medications can interact with alcohol, leading to increased risk of illness, injury, or death. For example, it is estimated that alcohol-medication interactions may be a factor in at least 25% of all emergency room admissions. An unknown number of less serious interactions may go unrecognized or unrecorded.

An Alcohol Alert brochure notes some of the most significant alcohol-drug interactions. (Although alcohol can interact with illicit drugs as well, the term "drugs" is used here to refer exclusively to medications, whether prescription or nonprescription.)

This brochure is available free of charge by contacting the Pharmacy Council on Alcohol Abuse (PCAA), P. O. Box 1336, Sausalito, CA 94966; phone (415) 332-4066; fax (415) 332-1832

Were You Harassed?

Have you been demoted, terminated or fired due to breach of confidentiality about medication you are taking?

People are being fired because their employers have found out that they were taking prescription medications such as antidepressants (Prozac, Zolof), anti-AIDS drugs (AZT), acyclovir (Zovirax), epilepsy drugs (Dilantin, Tegretol), heart medications, high blood pressure medications, cancer medications, or others.

Our non-profit public interest group is very much interested in sending a pack of information regarding your rights and we would like to hear from you if you have been passed over in your employment because of past medical histories that have been leaked to your employer by your insurance company.

Please call Pharmacy Defense Fund, 415-332-4066.

Women's Health Supplement Available

Drug Topics Magazine has printed a special supplement entitled "Women's Health and Pharmacy — An Overview of Patient Concerns." This supplement is available by writing Pharmacy Consumer Council on Women's Health (PCCWH), P. O. Box 1336, Sausalito, CA 94966 — Please include a self-addressed 9 x 12 stamped ($1.24 postage) envelope.

Continuing Education Programs

Presented by PPSI and PCAA
(Pharmacy Council on Alcohol Abuse)

New Treatments in Alcohol and Substance Abuse

Presented by:
Barry Bleidt, Ph.D., Pharm.D.
Marcus Cook, Pharm.D., M.B.A.
Darryl Inaba, Pharm.D.

Two hour accreditation

Learn the most up-to-date treatment for alcohol and substance abuse in these complimentary CEs

Choose the most convenient city for you!

July 9, Arizona Society of Hospital Pharmacists, 20th Annual Meeting, Syndham Paradise Valley Resort, **Scottsdale, Arizona**

July 13, Santa Clara Pharmacists Association, Mariana Restaurant, 2500 El Camino Real, **Santa Clara, California**

July 30, National Pharmaceutical Association, **Redondo Beach, California**

August 6, American College of Clinical Pharmacists, **Washington, D.C.**

August 31, Chemical Dependency Seminar, Second Annual Meeting, **Boise, Idaho**

September 16, Northwest PRN, Third Annual Meeting, **Seattle, Washington**

September 17, Northwestern Pharmacy Recovery Network, **Seattle, Washington**

September 29-October 1, Western Pharmacy Education Faire, (12 hour CE program), San Francisco Marriott, **San Francisco, California**

October 8, National Association of Retail Druggists, **Las Vegas, Nevada**

October 29, American Public Health Association, **San Diego, California**

November 19, American Society of Clinical Pharmacists, **San Francisco, California**

December 3-4, American Society of Hospital Pharmacists, Midyear, **Las Vegas, Nevada**

December 4, Pharmacy Council on Mental Health, Pharmacy Council on Alcohol Abuse, Awards breakfast honoring Marcus Cook, Pharm.D., M.B.A., **Las Vegas, Nevada**

PPSI Delegates Wanted

Looking for PPSI members to represent PPSI at the following meetings:

August 20-25
37th International Congress on Alcohol and Drug Dependence, La Jolla, California

August 26-September 1
55th World Congress of Pharmacy and Pharmacy Science, Stockholm, Sweden

September 15-18
British Pharmaceutical Conference, University of Warwick, Coventry, Great Britain

June 23-27, 1996
XX Collegium Internationale Neuro-Psychopharmacologogicum, Melbourne, Australia (mental health and alcohol abuse)

For more information please call PPSI, (415) 332-4066

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Prescribed
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IN THE COURTS

NEW HAMPSHIRE

Pharmacist-attorney **Richard Fradette** successfully represented **Medicine World Pharmacy** of Nashua, New Hampshire in a jury trial alleging defamation by a local health plan. Medicine World dispensed prescriptions to several plan members even though it was not a member of the network. The pharmacy alleged that the **Matthew Thornton Health Plan** then sent a defamatory letter to five of Medicine World's customers who were also members of the health care plan claiming that the pharmacy's actions may have been illegal. Three of the five testified at the trial. The defamatory letters were sent after Medicine World submitted ten claims totaling $37.06 for payment by the health care plan. The claims were denied and payment refused. The jury awarded $25,037.06 in damages. The jury incorporated the original $37.06 in claims, with the rest of the verdict attributed to the defamation.

MARYLAND

Maryland Governor Parris Glendening announced that he will enforce a statewide ban on **smoking in the workplace**, creating one of the nation's toughest anti-smoking laws. The ban, which took place on March 27, 1995, applies to all indoor workplaces except tobacco shops and laboratories investigating the health effects of tobacco smoke. Smoking will be permitted only in rooms specially ventilated to the outdoors. The smoking ban was proposed a year ago under state occupational health and safety regulations but was delayed by a legal fight. Maryland's highest court, the Court of Appeals, unanimously dissolved a county court injunction that had held up enforcement.

CALIFORNIA

A class-action lawsuit charging **Safeway Stores** with product liability, negligence, misrepresentation and unlawful business practices in selling **counterfeit Similac baby formula** has been filed in San Mateo County Superior Court. The suit was filed in Redwood City by **Girard and Green**, a law firm in San Francisco. It is believed to be the first civil action generated by the counterfeiting operation. According to investigators from the U.S. Food & Drug Administration, the counterfeiters bought bulk baby formula from a broker, repackaged it in phony Similac cans, then peddled it to supermarkets — including the Safeway chain — through a middleman in Southern California. The case remains under investigation by the FDA's Office of Criminal Investigations.

❦ ❦ ❦

The **Merck Medco Consent Injunction** in the Bacon Normandi case was issued on February 22, 1995 by **Judge Lowell Jensen** in the US Federal District Court in Oakland, California. The injunction states that Merck Medco will maintain an open formulary, that Merck shall cause Medco to appoint an independent pharmacy &

therapeutics (P&T) committee with the authority and responsibility to maintain the open formulary, and Merck shall cause Medco to provide a copy of the consent injunction to the P & T committee. Also Medco shall not provide, disclose or otherwise make available to Merck any Medco nonpublic information. Merck shall cause Medco to disclose the availability of the open formulary to all persons who currently have an agreement with Medco concerning PBM services or concerning inclusion of pharmaceuticals on a formulary, by providing to each such person a letter containing the following statement:

"Medco maintains an open formulary that allows, subject to the determination of an independent pharmacy and therapeutics committee, the inclusion of any ambulatory prescription drug product approved by the FDA for use in the United States. This open formulary will be provided to you upon request."

❦ ❦ ❦

In the PDF-instigated suit regarding Domel, Inc. dba Sail Drug and Discount Center vs. FHP, Inc. and FHP International Corporation, the case is awaiting trial after staving off a motion for summary judgment. The case is in U.S. District Court, Northern District of California, Judge Lowell Jensen.

❦ ❦ ❦

In the PDF-instigated suit regarding Sail Drug vs. Aetna Health Plans of California which dominate the Hemet, California market, attorney Joseph Alioto, Esq. has staved off a motion for summary judgment, and the case is in arbitration.

❦ ❦ ❦

Former president and CEO of Thrifty/Payless, Inc., Tim McAlear, has filed a $115 million suit claiming that he was wrongfully discharged in December. (A spokeswoman for the company says the suit is without merit — to coin a phrase.)

Editor's Note: This precipitates a thought: Will Thrifty's staff pharmacists have similar recourse when the conglomerate starts terminating them?

NEW JERSEY

Ortho Pharmaceuticals, a subsidiary of Johnson & Johnson, entered a guilty plea to charges of destroying documents pertaining to a federal government investigation into the promotion of a prescription drug for an unapproved use. The four-year government investigation, begun in 1991, looked into whether public and professional education programs conducted by Ortho in the late 1980s on the use of the acne drug Retin-A for photo-aging violated FDA regulations against promotion of a drug for an unapproved use. The company paid a fine of $5 million and an additional $2.5 million to cover the cost of the government's investigation. Johnson & Johnson said it discovered the document destruction in 1992 during the course of the investigation, and promptly reported its discovery to the Justice Department. Also, three senior employees of Ortho were separated from the company.

Druggists Call for Probe of Drug Makers

ORLANDO – Independent pharmacists called for a federal probe of alleged monopolistic practices of the nation's largest drug manufacturing companies.

"Attorney General Janet Reno should be convening a grand jury to investigate the anti-trust actions of three companies," said Lynn Carman, an attorney for the California based Pharmacy Defense Fund.

At a March press conference during the annual meeting of the American Pharmaceutical Association in Orlando, attorneys for the independent pharmacists described recent and pending mergers which tie 110 million pharmaceutical customers into three powerful "cartels," each owned by one of the nation's largest drug manufacturers.

"It doesn't take a rocket scientist to know that this isn't good for competition," said William Wentz, a Chicago attorney who is litigating a class action suit brought by drug stores including some chain stores against what he called a pricing conspiracy. The suit is scheduled to be heard in federal court in Chicago next year.

Joseph Alioto, the former mayor of San Francisco and lawyer for the Pharmacy Defense Fund, said the group is fighting the merger in which Merck & Co. purchased the giant Medco pharmacy benefit management (PBM) firm with 45 million customers; the merger of Eli Lilly and McKesson Corp.'s PCS Health Systems Inc. which has 55 million customers; and SmithKline Beecham's proposed merger with Diversified which has 10 million customers.

Carman said that the PBMs are "troublesome" customers for the drug manufacturers because the PBM has so much economic muscle it can demand and receive price cuts. Carman said that instead of establishing their own PBMs to compete, the major drug companies such as Merck and Lilly just bought the PBMs already doing business and they purchased the largest PBMs in the country. A PBM provides drugs for customers, processes customer claim forms, reviews the kinds of drugs customers are using, and negotiates rebates or discounts from manufacturers.

Alioto succeeded in getting a recent consent agreement with Merck, assuring that its Medco affiliate would open the list of drugs to be dispensed to competitors' products. The agreement also provided a "firewall" between Merck and Medco to prevent leaking confidential information about other drug manufacturers' pricing policies.

Alioto said the so-called "firewall" between Medco and Merck was welcome, but unlikely to work.

"This is a temptation to those companies that cannot be overcome. All it takes is a whisper on the phone or at the water fountain. It's akin to putting an alcoholic alone in a room with a bottle of whiskey," he said.

Ultimately, Alioto said, the pharmacists are seeking a government requirement that the drug companies divest themselves of PBMs. Alioto called the mergers examples of illegal vertical monopolies reminiscent of the octopus-like stranglehold railroads historically held over farmers seeking to send produce to market.

The attorneys said monopolistic practices being fought are drug pricing schemes in which independent drugstores have to pay as much as ten times the cost for the same drug as participants in the PBM plans; requirements that drugs be switched from one brand to affiliated company brand; illegal tie-ins requiring purchases of certain items for other benefits; illegal knowledge of competitors' pricing policies.

Alioto said the lawsuits represent "a fight for survival for pharmacists," and ultimately their customers. He said the actions of the giant mergers should be scrutinized by the federal government.

"I don't know why a Justice Department investigation isn't being done," Alioto said, "If these kinds of activities were being done by an oil company you can be sure the federal government would be investigating. We certainly want to encourage them to do this."

A spokesperson for Reno referred calls to the Federal Trade Commission. A spokesperson for the FTC, Claudia Bourne Farrell, said "All FTC investigations are non public." She said the FTC could not confirm or deny if there were any investigations of the mergers. In the FTC consent decree in the Lilly/PCS case, Lilly agreed to ensure that its drugs should not be given unwarranted preferences over competing brands, and Lilly also agreed to build a "firewall" to protect sensitive information of competitors.

That settlement was approved last November in a 2-1 vote by FTC commissioners. Commissioner Mary Azcunenaga dissented, stating that the consent order "exudes a lack of conviction in the underlying theory of competitive harm on which the order is based. The order does not cure the competitive problems alleged in the complaint."

Jerry Feitelberg, a pharmacist in Alameda, California, said, "Patients do not realize how they are being manipulated through these mergers for profit by the drug manufacturers."

Rx: Marijuana?

Arnold E. Vasa, R.Ph.
Vice President, PPSI
Sausalito, California

The California Assembly has approved a bill allowing marijuana as a medicine, but it remains illegal under federal law. The bill would allow doctors to prescribe marijuana cigarettes to terminally or chronically ill patients, despite the objections of some Republicans that it would promote illegal drug use.

If the bill becomes law, doctors would be allowed to prescribe marijuana for patients with AIDS, cancer glaucoma or multiple sclerosis, and pharmacists would dispense it.

"The doctors all agree scientifically that it (marijuana) relieves nausea, it relieves pressure in glaucoma and it helps you get your appetite back if you have AIDS," according to pharmacists. The idea has run into problems in Sacramento before, in part because any change in state law would require the federal government to change a policy that bars prescribing marijuana cigarettes anywhere in the United States. As of last October, 36 states - including California, Texas, New York and Florida - had written President Clinton asking him to change the federal policy.

The conservative objection is that this is just an open-door policy to get marijuana on the street and would only send a message to young people that it's fine to smoke marijuana to feel better.

The bill must be passed and signed by Governor Wilson to go into effect. Last year Wilson vetoed a similar bill because he said it would not work unless the federal government lifted its ban on prescribing marijuana cigarettes.

This bill has the same problem. It could not take effect unless the federal government changes its policy of allowing only the use of orally administered THC, the psychoactive ingredient in marijuana.

Synthetic marijuana (Marinol) is approved by the federal government for some patients and can be prescribed in California. Backers of the bill argued that smoking marijuana works faster and better.

Mark Your Calendar

July 17, 1995, Monday
PPSI Board of Directors
Open Meeting
Alta Mira Hotel
125 Bulkley Avenue, Sausalito CA
(415) 332-1350
Call for hotel for special rates

Drug Wholesalers May Face Limited Exposure in Pricing Suits

Agreement between 26 drug manufacturers and 6 drug wholesalers

by Cody Holt
Reprinted with permission from American Druggist, March 1995

Although six drug wholesalers were named as defendants in several federal antitrust lawsuits filed by retail pharmacists since 1993, their exposure to damages may be limited before the first arguments are heard.

According to a "judgment sharing agreement" between the six named wholesalers and 26 manufacturer-defendants, effective Oct. 26, 1994, each wholesaler is limited to a $1 million liability should the pharmacies win a judgment at trial, which is set to begin Feb. 5, 1996. But, in the event of a settlement, wholesalers will not make any contribution, leaving the entire amount payable to the manufacturers.

Kevin Rogan, general counsel for FoxMeyer Health in Carrolton, Texas, one of the six wholesaler-defendants, claims that even the plaintiffs in these cases say wholesalers have little to do with the "discriminatory pricing" charges directed at the manufacturers.

He cites the *Illinois Brick* U.S. Supreme Court case, which requires plaintiffs to sue only the party they purchase from, in this case wholesalers. Otherwise, he says the wholesalers wouldn't be involved in the litigation.

"This is really (the manufacturers') battle," Rogan says. "Because the drug wholesalers have a business relationship with them, they probably thought the wholesalers were victims of circumstance."

But Michael Freed of Much, Shelist, Freed, Denenberg & Ament in Chicago, co-lead counsel for the plaintiffs, says the drug wholesalers are part of the problem. "The wholesalers were named because our investigations showed that they were involved with the cartel" in fixing prices, says Freed. "And we believe the sharing agreement is a furtherance of that illegal cartel."

Freed says the sharing agreement provides wholesalers with an "incentive to stay in the conspiracy. If you're doing something that you might get in trouble for and then someone comes along with deep pockets and says 'keep doing this and I'll protect you,' you're probably going to keep doing it," he reasons.

Under the agreement, manufacturers have also agreed to provide $9 million to reimburse any litigation fees. In return, each wholesaler agrees to release "certain claims" that it might have had against the manufacturer-defendants.

Freed filed a motion to set aside the sharing agreement, claiming that it is illegal and against the public interest. The court is currently considering the motion, with a decision likely this month.

Besides FoxMeyer and Bergen Brunswig, other wholesalers and manufacturers contacted for this story declined to comment. The other wholesalers involved with the agreement are: McKesson, AmeriSource, Cardinal, and Bindley-Western.

NEW SUIT *Continued from Page 1*

exclusive contracts for long periods involving prescription drugs for millions of retirees and workers restrain competition unreasonably because they remove millions of prescriptions from the competitive marketplace for years at a time. All we wanted was the right to bid to keep those dollars in California instead of diverting them to Medco's Las Vegas mailorder operation."

Carman pointed out that the complaint also charged Medco-Merck with creating similar long-term exclusive contracts with General Motors, General Electric and the U.S. Postal Service for their workers and retirees.

CO-OP BUYING

One of the benefits of being a PPSI member is to join APC (American Pharnacy Cooperative), a buying co-op with no fees or dues. APC has contracts with several manufacturers whose products may be purchased through three wholesalers (who cover the national scene) or direct from participating manufacturers.

If interested, call Heidi Mayer at APC for more information or an application. Her telephone number is (415) 388-8438.

News and Comment

FDA Under Attack

Joseph I. Rotenberg, R.Ph.
Vice President, PPSI
Tiburon, California

FDA Commissioner David Kessler, M.D. is one of the main targets of the Republican majority in Congress.

The current debate, unfortunately, has as much to do with the influential and wealthy tobacco lobby as it does with any genuine policy debate over the merits of government regulation. Tobacco is threatened by an internal FDA study of the cigarette industry and a test of the agency's theory that the weed is actually a drug.

FDA's premises are that the vast majority of tobacco users smoke for the drug effects of nicotine and to sustain addiction and that cigarette manufacturers control the levels of nicotine in cigarettes to maintain this addiction.

Kessler has said that "few public health issues are more important" than preventing nicotine addiction. King tobacco is prepared to fall on its sword over this, and the latest round of attacks by advocacy groups and federal regulators, and it plans to take some major players down with it.

As Commissioner, Kessler sought truth in labeling of health claims from the dietary supplement industry. FDA's primary concern was that any health claim — that a substance cures impotence, for example, or protects against cancer — be truthful and backed up by significant scientific agreement.

Other health claims are regulated in this way under the Nutrition Labeling and Education Act, which was passed in response to consumer demand for accurate labels in 1990. Dietary supplements were exempt for a year.

The $4 billion year supplement industry found an influential ally against regulation in Senator Orrin Hatch (R-UT) whose home state of Utah has an important stake in the industry. Hatch opposed Kessler at every turn and introduced legislation that would permanently exempt dietary supplements from most FDA controls.

The war between FDA and the industry ended when Congress passed compromise legislation which establishes a commission to study and provide recommendations to Congress for the regulation of label claims and statements for supplements.

NEW LAWS AND REGS FOR 1995

E. William Kean, P.D.
Sausalito, CA

The California Legislature has passed several new laws that affect pharmacy. Here are some of the most important ones:

SB 1642 was sponsored by Senator Craven. It allows physician assistants (P.A.s) to prescribe or dispense medicines. The P.A., supervised by a physician, may administer medicine, or transmit an order to the pharmacist (either orally or written). The P.A. *must* print or stamp his name on the order along with his "furnishing number" provided by the board. The supervising physician's name *must* appear on the order also. The P.A. cannot order Controlled Dangerous Drugs. (However, he may phone in an order for a C.S.A. drug if the *physician* has written the order.) The P.A. must follow protocols for the practice. It is recommended that pharmacists request a copy of the protocols from local P.A.s.

SB 1816 was sponsored by Senator Torres. In the past patients had to pay for their own lab tests and medicine when they underwent clinical trials. This bill requires health insurance to cover these aspects of treatment.

SB 2036 sponsored by Senator McCorquodale, enacts a "sunset" on all professional licensing boards. Each board must justify its existence every five years. This bill was due to the recent medical board scandal — the board shredded 300 citizen complaints because they had too many to process.

The Board of Pharmacy is proposing to fine violators. The BOP Inspectors would be empowered to issue "tickets" on the spot for violations discovered. Licensees (pharmacy owners, pharmacists-in-charge, and dispensing pharmacists) who violate the consultation regulations would be fined $2500 (proposed first offense). The licensees will be held jointly or independently liable depending on the circumstances. For example, if the relief pharmacist is observed to be "not consulting" he would be liable for the total fine. However, if the pharmacist-in-charge did not schedule enough ancillary help, he too would be liable. If the pharmacy owner refused to allow the necessary help, then he (or the corporation) would be liable. It behooves all pharmacists to document all requests for help. Keep concise records. File an Incident Report if needed. (Nurses presently report staff shortages to their boss via e-mail; perhaps pharmacists should use this technology too.The Board of Pharmacy has hired four new inspectors and a chief. Guess who's paying for them!

Testimony Presented to the White House Conference on Small Business

My Name is Robert J. Fay, President of F.&H. Consulting and a member of the National Advisory Board of Pharmacy Planning Services, Inc., a non-profit national organization of approximately 2,100 pharmacists who practice in a variety of community, institutional, academic, public health and government settings.

Small businesses, such as pharmacies, have a major problem in survival in this country and we are losing over 1% of our community pharmacies every month. We had 59,000 twenty years ago, and these have dropped to 29,000 — some being replaced by chain drug stores, HMO pharmacies and mailorder pharmacies.

The two main reasons community pharmacists are closing their small operations are:

1. Discriminatory pricing on prescription drugs, where preferred classes of trade are sold the same prescription drug for 10 cents on the dollar, and the community pharmacy and chain drug store must pay full price.

2. The insurance industry, which practices predatory pricing mandating that pharmacies take low fees to do business with them. These contracts are underpriced so community pharmacists can not survive. Last year the National Association of Retail Druggists, (NARD) supported H.B. 9 which would have eliminated the McCarran-Ferguson exemption for insurance companies involved in pharmacy reimbursement.

Speaking for our PPSI members, the small community pharmacists need help from the White House Conference on Small Business. We are asking for:

1. A federal investigation on discriminatory pricing for prescription drugs.

2. The removal of the McCarran-Ferguson Exemption for insurance companies involved in pharmacy reimbursement.

Our association joins with national and state pharmacy and chain store groups asking for help.

Letter to Merck P&T Committee Members

Neal L. Benowitz, M.D.
Professor of Medicine, Psychiatry & Pharmacy
U. California School of Medicine
S. F. General Hospital
Occupational & Industrial Medicine
San Francisco, CA

Dear Dr. Benowitz:

We have received your name from the Bacon-Normandi Corporation vs. Merck & Co., Medco Containment Services, Inc. Consent Injunction which was issued February 22, 1995 and was publicized in the Report of Compliance of Merck & Co., Inc. and Medco Containment Service, Inc. with the Court's Consent Order dated February 22, 1995, Case No. C-93-2937-DLJ (enclosed).

The enclosed states that you are a member of an independent Pharmacy & Therapeutics (P&T) Committee that has been established by Merck-Medco, with your listed qualifications.

We have received the two enclosed letters addressed to Mrs. Erika Wodinsky, Federal Trade Commission, and Warren H. Barnes, J.D., California Department of Corporations, regarding the switching from Bristol's Pravachol to Merck's Zocor. We would like to find out the following:

1. Did the P&T Committee meet to authorize this specific switch from Pravachol to Zocor? If so, would you please send me a copy of the decision and how it was made, when it was made and what rationale you used in ascertaining the switching on the Merck-Medco formulary?

2. Does the P & T Committee utilize the cost of the medication before switching in the case of Pravachol to Zocor? If so, would you please send us information on how this decision was made, who made this decision and any pertinent information as to why this decision was made, since Zocor costs $1.27 more per pill for the switch? Were you aware of this when you authorized this formulary switch?

3. Does the P & T Committee know about the California state laws regarding switching drugs without calling the practicing prescriber for a physician authorization? If so, would you be kind enough to respond to the enclosed letters? "The notice advised our customer that their prescription had been authorized to be switched from Squibb's Pravachol tablets to Merck's Zocor tablets. The notice instructed our pharmacist (Vons) to call the physician to obtain authorization for the switch. Upon contacting the physician regarding the switch from Pravachol to Zocor the physician stated he had not been contacted by PAID Prescriptions contrary to the wording of the notice."

We would greatly appreciate understanding how the P & T Committee appointed by Merck-Medco works, when you get together, how you review drug formularies, and how you determine which drugs go on the formulary. Any guidelines or standards of practice that you utilize would be greatly appreciated as we are concerned about some of the switching and how the formularies are determined by you and your committee.

We would be more than pleased to hear from you at your earliest convenience.

Sincerely,
Frederick S. Mayer, R.Ph., M.P.H.
President, PPSI

Editor's Note: This letter went to all nine members of the P & T committee. PPSI also wrote to the FTC Bureau of Competition requesting it to look into the matter and any possible financial relationship between the committee members and Merck-Medco.

PBMs *Continued from Page 1*

general fund profits from similar arrangements to the tune of $150 million last year in rebates paid by the manufacturers for the privilege of having their products on the Medi-Cal formulary. Mike Neff who negotiates the rebates for the Department of Health Services appears later on this program.

The intense competition for formulary space was shattered when Merck (the largest pharmaceutical manufacturer in the U.S. at the time) paid $6.6 billion to Medco (the second largest PBM) to assure that their products would be on the list. Up to that time, drug stocks had fallen in disfavor on Wall Street. Profits were flat, the market for Merck prescription drugs was sluggish, even though they took full page ads to push their products in the newspapers and magazines.

The acquisition of Medco did for Merck what their product line couldn't do. It increased their market share. Wall Street saw at once the advantages of a vertically integrated system where the manufacturer could control the price, distribution and marketing of their product from factory floor to patient gullet.

The Merck-Medco merger has paid off. They have increased their beneficiary rolls by 21%, they went from 33 to 40 million insured. The sale of Merck products has increased 42% to $15 billion with the highest profit margin in the industry (20%). In contrast, retail pharmacies' profit margins are in the neighborhood of 3%.

The promise of high profits encouraged other pharmaceutical manufacturers to buy PBMs to ensure formulary space and enhance their bottom line. When the FTC reviewed the Lilly-PCS multi-billion dollar marriage, they imposed a few conditions, namely that Lilly can't exclude a competitor's products from the PCS formulary and that a firewall must be maintained whereby Lilly cannot know what prices its competitors are bidding to be included in the restrictive PCS drug formulary.

The Pharmacy Defense Fund received similar concessions from Merck-Medco in a consent injunction in Federal Court. If you believe that the sales people at Lilly won't speak to the sales people at PCS, that the Merck executives won't take the Medco staff to business lunches or that the FTC can enforce such a ruling, you'll readily believe that my cat plays the violin.

The immediate result of all these financial take-overs and formulary shuffles is that physicians have lost their right to prescribe the product of choice for their patients and pharmacists can no longer select the most cost-effective therapeutic agents for their customers. Recently, CIGNA, a large insurance company, implemented a formulary change which established ZOCOR (a Merck slow mover) as the exclusive cholesterol inhibitor for their members. We can assume that the move was profitable for both the Merck and Cigna corporations, but you may wonder what benefit will derive to the poor patient. Will he get a rebate check? In fact, the benefits structure of the pharmacy benefit management plans is designed to benefit their corporate sponsors, not the patients.

The latest offspring of the pharmaceutical manufacturers-PBM marriage is *disease management.* Once a physician arrives at a diagnosis for a patient, this diagnosis can be entered into the patient profile along with the disease management protocol for that particular diagnosis. Now treatment can be instituted by computer, the pills and the drug literature can be delivered by the mailman, and the progress of the patient checked by a clerk reviewing the invoices as a form of iatrogenic computer roulette.

For example, I suffer from severe congestive heart failure. My cardiologist has me stabilized by using ACE inhibitors, beta-blockers, vasodilators, diuretics and other drugs, many not on most CHF protocols. When the disease management phase of my managed-care plan kicks in, my cardiologist expects to be harassed to switch my Capoten to Vasotec, the Merck ACE inhibitor. It happens that I once took Vasotec and it almost killed me. I developed emphysema and chronic respiratory problems. When and if this happens, will I blame the insurance company coronary heart failure disease manager in New Jersey for pushing his company's product? Of course not! He is not to blame. His job depends on how many Capoten prescriptions he can switch to Vasotec.

I will blame the lack of enforcement of our state laws on the political hacks on the Board of Pharmacy that permit unlicensed, unqualified, unregulated individuals to practice computer medicine without a California license. I will blame physicians and pharmacists for allowing their professional prerogatives and clinical judgment in the care of patients to be superseded by flaky data entered into computer programs. I will blame the authorities for their lack of enforcement of the laws that are currently on the books like the Health Care Service Act or Knox-Keene which should regulate the activities of the PBMs in California and give patients some measure of protection.

Before you dismiss the threat of disease management as a therapeutic no-brainer, it is already here. This year Blue Cross of California is planning to link the Blue Cross medical data base with Medco's formulary so they can manage, long distance, the following hot seller diagnoses: asthma, high blood pressure, peptic ulcers, diabetes, high cholesterol and migraine. Another drug company called Zeneca, the world's second largest maker of cancer products has purchased one half of Salick Health Care which operates 10 cancer treatment centers in Los Angeles.

If you believe that the Salick Cancer Treatment clinics will not favor Zeneca's products over the products of other companies' cancer treatment drugs and that Medco's formulary will not push the Merck products, you'll believe that my cat, Sam, is a virtuoso violinist.

The confidentiality and privacy issues about disposition of the health records of patients who deal with PBMs should be addressed in the courts. Recently, I was shocked to read the following sentence in an RFP put out by Optima: *"The member's medical record is the property of the provider who generates the record."* The key word in the sentence is the word *property*. If you don't believe that you can lose your property without your consent and knowledge even in Orange county, let me assure you that until the courts rule otherwise, you can.

Patient data belongs to the patient; it does not belong to the physicians, the hospitals, the pharmacy, the drug-company-owned PBMs, the employers or the insurance companies. When data are transmitted by providers of health services to payers, it is only done to facilitate claim payment for the patient's benefit. Those data bankers who steal these data from the patient and the provider without their knowledge or consent, who manipulate them and resell them at a profit are engaged in a behavior best characterized by an old saying:

He dat takes what izzen hissen,
Should put it back or go to prizzen.

It is important that we remind ourselves that these so-called patient and provider profiles are cobbled together from invoices. These data are, by definition, inaccurate since they are derived from secondary sources of dubious precision. Drugs prescribed are often substituted, days supply are mostly wrong, drugs are often prescribed for conditions other than those listed on the claim form, the patient may get the prescription filled and never take a dose — it may wind up being fed to his dog or his mother in law. There is no check on the actual fate of the prescription at the patient level.

That these drug claims can be used to develop patient and provider profiles and become a profitable source of revenue for PBMs is ludicrous. That they may become the primary documents for disease management by the PBMs represents a public health menace.

We tried here to give brief history of PBMs, and some of the dangers they represent to health care if they remain unregulated and unchallenged. Last year we saw a lot of TV ads about the evils of socialized medicine, when Harry and Louise would lose their right of choice. Their choice of doctor would be taken away from them; treatment would be rationed; access to treatment would be restricted by a large and incompetent health bureaucracy.

As a patient and a pharmacist, I hope that by the last session of today's seminar, I will have become enlightened about the subtle differences between managed care, managed costs," PBMs and a system of corporate socialized medicine that rations patient care to improve the corporate financial bottom line.

Thanks for Alcoholism Features Last Issue

Editor,

Many, many thanks for your fantastic articles and the "Alcoholism is Nothing to Hide" poster in the center of the Spring 1995 PPSI Newsletter.

For pharmacists who wish to educate themselves about alcohol and substance abuse there are two new fantastic books by Marc A. Schuckit, M.D., Professor of Psychiatry, University of California, San Diego available entitled *Drugs and Alcohol Abuse, A Clinical Guide to Diagnosis and Treatment, Fourth Edition* and a second book *Educating Yourself About Alcohol and Drugs, A People's Primer.*

To order these books please contact Georgia Prince, Plenum Publishing Corporation, 233 Spring Street, New York, New York, 10013, or telephone 1-800-221-9369.

As a special to members of Pharmacy Council on Alcohol Abuse (PCAA) and PPSI, a 10% discount is offered when ordering one book and 15% discount if both volumes are ordered.

Sincerely,
Barry Bleidt, Ph.D., Pharm.D., R.Ph.
Co-Chairman, PCAA
Indianapolis, Indiana

Editor's note: 5,180 PCAA kits were mailed to all California pharmacies for the June, 1995 "Pharmacists Declare War on Alcoholism" pilot program. 70,000 PCAA kits will be sent out in December for the national campaign. If you wish to get involved, please call Arnold Vasa, R.Ph., Vice President, Professional Affairs in care of the PPSI office, or fax us (415) 332-1832 and request an alcohol kit.

Estrogen Bioequivalency

John A. Gans, Pharm.D.
Executive Vice President
American Pharmaceutical Association
2215 Constitution Avenue, NW
Washington, DC 20037-2985

Dear John (if I may):

I am in receipt of a copy of your letter to Dr. Kessler regarding the approval of a generic version of "Premarin," and write to point out what I feel is an error of omission.

The absence of an inactive ingredient is generally regarded as having little, if any, impact on the overall biological activity of a product. When five of six active estrogens are present, and the inactive molecule absent, there would seem to be neither a diminished biological activity nor a threat to any patient. My perception is one of loud screams of rage and fear emanating from a firm that has had about 50 years of little competition for the market of estrogen replacement. During the years that other producers were marketing generic conjugated estrogens my recollection is that the threat was to Wyeth's net profit, not to the patient.

When I had the less costly generic available to dispense to my patients I had no reports of diminished effect nor of injury to patients receiving the lower cost product. The feeling has been that the Premarin producers found a window through which they could throw out the competition.

As a community pharmacist concerned with bioequivalence as well as the patients' pocketbooks, I feel that APhA should refrain from supporting the wants of a firm that has earned more than its fair share of profits from a product that has been available for over half a century.

I look forward to your response.

Sincerely,
Morris Boynoff, B.S. Pharm.

More on Estrogen

Dear Fred:

A few days ago Jordan Cohen shared with me a copy of your letter to the Bioequivalency Advisory Panel with regard to the conjugated estrogen bioequivalency issue. I was delighted to see that you have encouraged thoughtful evaluation of this issue and its impact on patient care, especially with a drug product that will increasingly be used on an aging female population in the United States.

I have been carefully following the conjugated estrogen bioequivalency issue for the last several years. I am not convinced from any human data available in the literature that the delta 8,9-dehydroestrone has any significant contribution to the activity of Premarin and until such data is available from human studies I remain supportive of the FDA approach that could lead to the approval of several generic versions of conjugated estrogens.

I am supportive of the position to proceed with generic approval and hope that your Bioequivalency Advisory Panel will do the same.

Sincerely,
Thomas S. Foster, Pharm.D.
Professor and Director
Center for Pharmaceutical Science and Technology
University of Kentucky

Primetime Reaction

Dear Editor,

Your opening greeting last issue raised my spirits considerably. All the other pharmacy journals have headed like lemmings over the cliff of "reimbursement for cognitive services."

The Diane Sawyer program on pharmacy errors has also been well reviewed, but nowhere has anyone asked: "Were those all valid prescriptions for valid customers?" I must wonder if Ms. Sawyer's experts in prescription errors had stacked the deck with prescriptions specially chosen to increase the chance of a dispensing error. Will Diane comment on this point?

Marion Steinback, R.Ph.
Banks Pharmacy
Banks, Oregon

UC School of Pharmacy Using Mailorder Rx

Ms. Michele French
Director, Health Welfare Benefits Program
Office of Senior V. P. for Administration
University of California
300 Lakeside Dr., 5th Floor
Oakland CA 94612

Dear Ms. French:

We are writing this letter regarding the fact that the University of California School of Pharmacy, the number one school of pharmacy — judged by the U. S. News & World Reports for five years running — is getting prescriptions filled through CALPERS in Las Vegas by mail order.

We have written to Dean George Kenyon of the U.C. School of Pharmacy and we were wondering if you would look into the following issues for us:

1. Over 240,000 people over 65 are going to the hospital each year because of mixing up of their drugs, with 100,000 dying at a cost of $10 billion. How do you expect the over-65 retirees from U.C. who are filling their prescriptions by mail order to get consultation?

2. Consultation is required by Federal Law OBRA '90 and also required for all new prescriptions in California. Why have you denied the U.C. folks this basic health care privilege?

3. Would you send us information on why you continue to use this mailorder firm, which does not pay California taxes, while all California chain and independent pharmacies do pay taxes which subsidize you as California employees?

4. In Nevada there is no strict law regarding technicians filling prescriptions or numbers of technicians that can fill prescriptions, whereas in California we have standards of practice which prohibit technicians from checking technicians.

5. Why have you chosen to put U.C. graduates from the UCSF School of Pharmacy out of business by having your 100,000 employees do business in Nevada?

Many, many thanks for your kindness in looking into this matter. Is it a matter of getting a better deal in Las Vegas without consultation and a mailperson delivers the prescription? By using the mailperson as a pharmacist, perhaps we do not need a UCSF School of Pharmacy. Perhaps it is senseless for us to support the fundraising causes of U.C. since apparently U.C. Berkeley thinks so little of the number one school of pharmacy by having such a poor system.

Sincerely,
Phil Grauss, Pharm.D., President
Marin County Pharmaceutical Assn.

cc: George Kenyon, Ph.D., Dean, UCSF
Robert Gibson, Pharm.D., Associate Dean, UCSF
Luther Johnson, Pharm. D., President, UCSF School of Pharmacy Alumni
Frederick S. Mayer, R.Ph., M.P.H., AAUCSF Board of Directors
and others deleted for brevity

APhA-Merck a Sellout

John A. Gans, Pharm. D.
Executive Vice President
American Pharmaceutical Assn.
Washington, DC
Dear John:

From what I see, read and hear involvement of APhA with Merck was a sellout of the profession of pharmacy for economic greed.

Would you prepare a financial report covering APhA dealing in the APhA-Medco-Merck fiasco for presentation to the House of Delegates at the next convention? I am certain readers of American Pharmacy would find this most interesting.

In the field of professional services, it is a shame that APhA should have endorsed a depersonalized, professionally-incomplete mail-order operation to act competitively and economically against the intimate, personalized, professional services provided by the individual community practitioner. The training, knowledge end experience of the licensed professional is of little value to the pharmacist or the patient, with incomplete data, when the patient be directed to multi-source medication providers.

APhA seems to ignore the basic RPH principle for solving problems, wherein *reality* is definitely established, where *practicality* of the solution is thoroughly considered, and where ***honesty*** permeates the complete transaction.

APhA is guilty of PIIG (policy in ignorance). Ignorance is not a crime, the crime is with policy-setters who display dishonesty to themselves and others, when they find it too difficult or inconvenient to become completely informed before they assert themselves in policy determinations. The disservice to all is obvious.

APhA should turn to its obligation to the profession in the economic and professional entities for the best interests of the consumer of pharmacists' services, rather then its involvement in "sweetheart deals" with drug manufacturers.

I am requesting your reply.
Yours truly,
A. F. (Sandy) Demetro, R.Ph.
Westwood Prescriptionists
San Jose, California

APhA Replies

Dear Sandy:

I appreciate the sincere and forthright tone of your letter. There are a few things I want to make sure are clear in your mind regarding the exact nature of the relationship APhA established with PAID Prescriptions and why our Trustees decided to be involved.

Our endorsement related only to the concepts of the new network strategy intended for the Coordinated Care Network. APhA believed this approach could initiate changes in pharmacists' compensation for the services provided to patients. I realize that this has become blurred in communications which have circulated throughout community pharmacies over the past several months. APhA *did not* receive any financial remuneration for this endorsement. APhA did develop a special report for educational purposes relating to pharmacists' involvement in managed care, sponsored by Merck/Medco. This is similar to products sponsored by other pharmacy organizations. Also, in cases where our representatives were asked to attend meetings regarding the Coordinated Care Network, some of our expenses were reimbursed by Merck/Medco.

APhA's decision to endorse the concepts embodied in the Coordinated Care Network was based on a recognition that reimbursement for dispensing prescriptions was in a free fall with no apparent end in sight. Unless pharmacists began to receive compensation for the services they provided the future would be worse than bleak. We have tried to work with other pharmacy benefits managers like PCS for years, with no response.

In September, 1994, the Board of Trustees of the American Pharmaceutical Association released the "Pharmaceutical Care Benefit Principles" to further advance pharmacists' role in the delivery of pharmaceutical care. An implementation plan has been developed to promote these principles to payers, employee benefit managers and patients. This shift in strategy was developed based upon the changes occurring in the marketplace and feedback received from pharmacists and benefit managers.

These are extremely difficult times of change and uncertainty, perhaps unlike any other you have experienced in the years you have been in practice. APhA believes that the future of independent pharmacy will be secure only if we take decisive action to insure that those people who purchase prescription drug coverage, whether individually or in a group, realize that they are purchasing more than just medications — they need access to your services to insure those medications produce a positive outcome. It has become clear that reimbursement for simply dispensing prescriptions is insufficient to sustain our professional practice. APhA has not lost sight of its obligation to the profession and the patients it serves.

Again, thank you for taking the time to share your concerns about our activities and the future of our profession.

Sincerely,
John A. Gans, Pharm.D.,
Executive Vice President, APhA

Condom Museum in Condom, France

Dear Mr. Mayer:

The Mayor of Condom, Mr. Jacques Moizan, forwarded your letter to me.

For the present, we are discussing the "Condom Museum" project which is planned to be finalized two years from now. I am in charge of the medical aspects of the project.

We are, of course, very interested in PPSI's proposal, and look forward with pleasure to your collaboration in this matter.

To begin with, we must make an inventory of objects and documents that can be gathered and displayed in the museum collection.

Have you any ideas how we can begin our collaboration? How can you, PPSI, aid us in this venture?

Sincerely yours,
Docteur Alain Berrébi
Adjoint Chef de Service
Hôpitaux de Toulouse

PPSI Replies

Dear Dr. Berrebi,

The Condom Museum project interests me very much. I have many ideas about our collaboration that I will present in outline format first, with details to follow: 1) Organize an International Committee for the museum with 10 members; 2) Ask the NIH for help with posters — we have 12 and should find others from around the world; 3) Do an exhibit on the history, invention and controversy of the first condom; 4) Exhibit with 30 manufacturers of condoms — colors, sizes, different types; 5) Evolution of the condom — past, present and future, 3-6-12 packs, marketing, manufacturing, advertising and distribution; 6) Film on the making of condoms — quality and reliability testing — rubber vs. lamb skin vs. plastic; 7) Film on how to use a condom" and "Safe Sex"; 8) Posters-photographs (wax figures) of the famous people in the history of condoms, famous stories, myths, films about condoms; 9) Condomania outlet in the museum with books, videos, condoms and safe-sex paraphernalia.

(Detailed suggestions deleted for brevity)

If I can be of any further assistance, please be very specific in your next letter.

Sincerely,
Fred Mayer, R.Ph., M.P.H.
President, PPSI

Condoms, Pregnancy and AIDS

RE: Your article on National Condom Week and October AIDS Awareness Month

Dear Editor:

I want to send you the enclosed article on "Pediatricians say Condoms Should be Available in Schools" and that the highest rate of teenage pregnancies of any developed country is in the United States, and the number of teens with HIV infections doubles every fourteen months.

Why don't we do something about needle exchange programs through pharmacies. It works in Australia where needle exchange has reduced the HIV/IV users to 5%, whereas in the U.S. in some areas, like New York City, 70% of IV users are HIV positive, and in San Francisco it is 62%.

Gary Avnet, R.Ph., Co-Chairman
PPSI AIDS Committee
Sylmar, California

*Ed. Note: See **Faxback question**, Page 18*

In Memoriam

WENDELL T. HILL

Wendell T. Hill, Jr., Pharm.D., Dean of Howard University's College of Pharmacy and Pharmacal Sciences from September 1977 to August 1994, died on March 18, 1995. After serving in the Army during World War II, Dr. Hill attended Drake University where he received his B.S. in Pharmacy. He completed a two-year residency in hospital pharmacy at the VA Center in Los Angeles, and went on to obtain a masters degree and the Doctor of Pharmacy degree from the University of Southern California. Prior to accepting the deanship at Howard in 1977, Professor Hill served as Chief Pharmacist at the VA Center in Los Angeles (1954-1956), concurrently as Director, Orange County Poison Control Center and Chief Pharmacist, Orange County Medical Center (1957-1977). Dr. Hill has held elected offices in numerous associations and organizations, at the local and national levels. He has been recognized by his peers with such prestigious awards as the Bowl of Hygeia and Pharmacist of the Year from the California Pharmaceutical Association; Outstanding Alumnus by Drake University and University of Southern California; the Harvey A. K. Whitney Lecture from ASHP; and Pharmacist of the Year by the Washington D.C. Pharmaceutical Association.

ADELE ERENBERG

Adele Erenberg died on April 2, 1995 in Los Angeles, of heart disease. Adele, a long time community activist, was the Executive Director of the Council of Quality Healthcare Providers. She spent the last fifteen years of her life in the health care profession. She devoted her life to a myriad of social issues, including working to reform the California pasteurization laws in the 1950s and working with Los Angeles gangs in the 1960s. Her many title positions included directorship of the Greater Los Angeles Gray Panthers. She also worked for KABC-TV news as a researcher. Adele profoundly affected those with whom she worked with her candor, her sense of moral ethics, her astuteness, but most importantly, her wonderful sense of humor. Adele may be remembered with a donation to the Council of Quality Healthcare Providers, or a favorite charity.

Faxback Question

Should condoms be available in schools?

Yes, according to a new policy statement from the **American Academy of Pediatrics**:

"The U.S. has the highest teen pregnancy rate of any developed country, and the number of teens with HIV infection doubles every 14 months. Adolescents also are more likely than adults to suffer from infections that cause no symptoms and suffer lifetime consequences such as chronic infection, ectopic pregnancy, infertility and spontaneous abortions."

We welcome your comments, suggestions and thoughts on needle exchange, condom use for teens, and how to deal with the teenage pregnancy rate. Apparently, abstinence is not working, and we need your input.

FAX your comments to:

PPSI FAXBACK, 415-332-1832

Arthur M. Perlin, P.D.

to Receive George S. Maggio Award

Arthur N. Perlin, P.D. has been selected as the recipient of PPSI's annual George S. Maggio Award. The Award will be presented at the 14th Annual George S. Maggio Breakfast Meeting (7-9 a.m.) at the Hilton Hotel in Las Vegas, Nevada, Tuesday, October 10, 1995, during the National Association of Retail Druggists (NARD) 97th Annual Convention and Trade Exposition.

Art graduated from the Brooklyn College of Pharmacy in 1965. On graduation he received his appointment as a commissioned officer in the U.S. Public Health Service, later retiring as a lieutenant.

He was detailed to the Food and Drug Administration's Detroit district office, along with two other PHS officers who were pharmacists (FDA did not have pharmacists as drug inspectors). Art received a commendation from the FDA Commissioner for his discovery that ethylene oxide gas used in sterilizing medical equipment left a deadly residue. A paper that he co-authored was published and copies were requested by 37 countries.

In 1968 Art opened his pharmacy in Port Washington, New York. He became active in pharmacy organizations about eight years ago when he was elected to the Board of Directors of the Long Island Pharmaceutical Society. He was appointed by the Society to serve as political coordinator, which entailed organizing independent pharmacies into a grassroots political group. Since Art's appointment he has been involved in over 125 elections. Candidates supported by pharmacy have been successful over 95% of the time. On June 8, 1990, Art organized senior citizens and pharmacists from five states into a political demonstration against price discrimination in front of Pfizer's headquarters in New York. OBRA 1990, which included rebates to both state and federal governments from drug manufacturers on Medicaid prescriptions, was signed into law several weeks after the demonstration.

Ten years ago, Art was one of the nine founding members of the Independent Buying Group (IBG). IBG is the only pharmacy buying group in the United States dedicated to raising political action funds. He currently serves on the IBG Board and is the computer programmer for IBG. In 1991, as a board member of IBG, he filed an antitrust complaint with the FTC against Abbott Labs. The complaint was filed because of Abbott's refusal to give IBG a contract on the same terms as they gave to Medco.

Art is currently President of Long Island Pharmaceutical Society and Chairman of the Rx PAC of New York. He also serves on his state society's (PSSNY) legislative committee.

The long list of Art's accomplishments and numerous awards received in recognition of his other outstanding contributions to the profession are evidence of his distinguished achievements. The award he is most proud of is "The Toughest Pharmacist of the Year Award" presented by the Westchester County Society of Pharmacists in 1990. Other awards he has received are Pharmaceutical Society of the State of New York Special Service Award, 1989; Long Island Pharmaceutical Society Special Achievement Award, 1992; and Pharmacist of the Year Award, 1994. Art and his wife Marcia have two children.

Pharmacists Planning Service, Inc. (PPSI) is proud to honor Arthur M. Perlin with the 1995 George S. Maggio Memorial Award.

People in the News

Congratulations to PPSI Board Member **Robert Gibson**, Pharm.D. for receiving the 1995 "Cover Page Recognition Award" by *Drug Topics/Medical Economics*. Bob also serves as APhA Trustee

Timothy Chan, Ph.D. has been named Dean of the University of Southern California School of Pharmacy effective February 1, 1995. Dr. Chan had served as interim Dean since July 1, 1994. He had been department chair of Molecular Pharmacology and Toxicology, and succeeds PPSI's Distinguished Person of the Year former Dean John Biles, Ph.D.

The Santa Clara Pharmacists Association honored long-time leader and PPSI member **Bob Clifford**, R.Ph. at its recent Installation Dinner. Reinstalled as President was PPSI member Del Boccignone, R.Ph.

PPSI member **Dick Abood**, R.Ph., Esq. of the University of Pacific School of Pharmacy, Stockton, was re-installed as San Joaquin Pharmacists Association President. Dick is Professor of Pharmacy Administration and Past President of the American Society for Pharmacy Law (ASPL)

Judith D. Lane and **Ronald R. Quam** are the new Publishers of *Pharmacy West* following the death of **ElRoy FitzSenry**. The company named **Chuck Austin** senior editor of *Wholesale Drugs*. **John T. Fay, Jr.** was named the publication's Corporate Editor

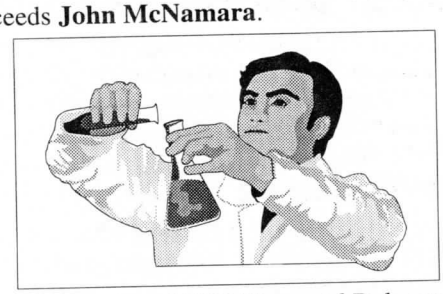
Popular pharmacist and PPSI corporate member **Jordan D. Johnson**, M.S., Manager, Pharmacy Affairs for Zeneca Pharmaceuticals, has taken retirement.

Recently elected President of the California Pharmaceutical Association is PPSI member **Alan Martin**, Pharm.D. from Economy Drug in San Luis Obispo. Martin's wife, **Edith**, is also a hospital pharmacist at Sierra Vista Hospital Pharmacy in San Luis Obispo. Congratulations!

PPSI Board member and PPSI Distinguished Person of the Year Award winner, **Raymond Olson**, R.Ph., retired Executive Director of the Washington State Pharmaceutical Association, was honored at WSPA's Midyear Meeting in Yakima, Washington.

Rodney D. Shafer, R.Ph. of Seattle is the new Executive Director of the Washington State Pharmacists Association.

The new Chairman of the National Wholesale Druggists Association is PPSI corporate member **Mel Whitmire**, Vice Chairman of Cardinal Health, Inc. Mel succeeds **John McNamara**.



Named to ASHP House of Delegates for 1995 by **Joseph A. Oddis**, Executive Vice President are California delegates **David S. Adler, Lawrence R. Borgsdorf, Beth Devine, Donald T. Rishi, Helen Macfie, Max D. Ray, Byron F. Schweigert,** and PPSI member **Glenn Yokoyama.**

The PPSI **George S. Maggio 14th Annual Award Winner** is PPSI member and President of the Long Island Pharmaceutical Society (LIPS) **Arthur Perlin**, R.Ph. of Port Washington, New York. *See Page 18.*

University of California San Francisco Alumnus of the Year Award was given to **Sam Kidder**, Pharm.D., M.P.H., Baltimore, Maryland, for his SNF work with HCFA.

PPSI President **Fred Mayer**, R.Ph., M.P.H. will be awarded the John Dargavel Award from NARD at their annual meeting scheduled for October 7-11, 1995 in Las Vegas, Nevada

Rob Waspe, Esq., National Association of Chain Drug Stores (NACDS) Corporate Counsel, has now opened up his own office for the practice of law. Rob was PPSI's keynote speaker last year in Boston at the NARD convention. He can be reached at 6628 Frost Lake Lane, Alexandria, VA 22315; fax (703) 971-1571.

New Vice President at the Pacific School of Osteopathy in Pomona, California (home of the new pharmacy school) is **Carl E. Trinca**, Ph.D., former Executive Director of American Association of Colleges of Pharmacy (AACP). Replacing Carl as new Executive Director of AACP is **Richard (Dick) Penna**, Pharm.D. Congratulations, Dick!

Marcus Cook, Pharm.D., M.B.A., Co-Chairman PPSI's Pharmacy Council on Alcohol Abuse (PCAA), Assistant Professor at Idaho State University School of Pharmacy, was awarded the Distinguished Public Service Award for developing state-recovery assistance programs for Idaho pharmacists. Marcus will be the keynote speaker at the PPSI NARD Education Program, October 10 in Las Vegas and the ASHP Las Vegas program, December 3.

PPSI member **David Breslow,** Pharm.D., has stepped in as the director of the California Pharmacists Association Academy of Pharmacy Owners. Breslow, a community pharmacy owner, will work with the board of directors and members to identify possible solutions to the problems facing independent community pharmacists and will work to inform independent pharmacists of coming changes in health care. To leave a voice mail message for Breslow, call 1-800-444-3851, ext. 371.

PPSI member **Gary Kadleck** will keynote the International Public Health Conference in Stockholm, Aug. 26-27. Gary will be running for president of APhA.

Pharmacists Planning Service, Inc.
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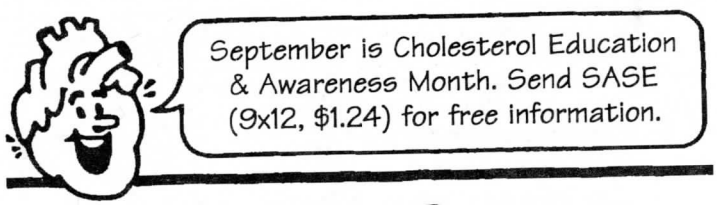

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